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THE TREATMENT OF SELF-LIMITED DISEASE.

By CARL E. BLACK, M. D.
JACKSONVILLE, ILLINOIS.

In calling attention to the subject of the treatment of self-limited diseases it is not intended to advance any new theories of treatment, advocate the use of particular drugs or methods, or to make any extended report of cases. The object is rather to present in a questioning way, some of the problems which perplex young men in medicine, some of the questions which are constantly presenting themselves to young men for solution. It is hoped that by suggesting some of these problems, satisfactory and complete explanations will be given by those who are full of wisdom, and rich in the experience of many years. Young men feel privileged to ask questions, and to expect those older in experience to answer them.

There are many things which are calculated to bewilder the student of medicine, but they are multiplied ten-fold after he has been in practice a few years, and has become acquainted to some extent with the habits of treatment pursued by the practitioners with whom he comes in contact. And his bewilderment is in no wise diminished by consulting authorities, for these he finds contain equally conflicting views and dogmatical statements. The young man soon discovers that he can find authority, more or less good, for almost anything.

The special object of this paper is to call your attention to a brief consideration of some points in the treatment of acute self-limited diseases. That is those diseases which run a more or less definite course, and tend to recovery. Please bear

in mind especially the last statement, "tend to recovery." Take as examples typhoid fever and pneumonia. These are as different as possible in the onset and in the course they pursue, and yet both have a more or less definite course, and both tend to recovery. A large number of such diseases could be mentioned, but those two will serve the purpose of illustration.

In every case of acute febrile disorder of a definite character we have general symptoms which are brought about by a systemic poison. The poison is generated in some seat of local inflammation, which is properly the seat of the disease. There is a sore with all the characteristics of an external local inflammation. In fact, in some diseases under this head, the seat of inflammation is external, or partially external, as in erysipelas, scarlet fever, etc.

The severity of each case depends on the extent of the inflammatory lesion, the amount of poison generated and absorbed into the system, and on the resisting powers of the individual.

The relative proportion of these three elements is infinitely varied in different cases. The systemic disturbance may be great from an apparently small lesion, or *vice versa*; the lesion may seem large and yet give rise to little systemic disturbance. The peculiarities of the individual and his surroundings have much to do with the severity of an attack of any acute disease.

It is a general proposition beyond dispute, that, by the time we are able to positively diagnose an acute disease of this class, it is too late to use any means to check it. To say that we have aborted a case of typhoid fever or pneumonia simply means that we have failed to make a diagnosis, and it would be far better to be honest enough to acknowledge that the typhoid fever or the pneumonia had not existed at all, and that we had simply been mistaken, instead of trying to hum-

bug the patient and his friends into believing that we had accomplished a great and wonderful thing.

When typhoid fever exists,—that is when the inflammatory process is begun in the intestinal glands and sufficient general symptoms have been produced to enable the physician to make a diagnosis,—the disease is there, and will run its course in a fairly definite way in spite of all abortive measures ever tried. When the lung is attacked with pneumonic process, and we have the signs and symptoms on which to base a diagnosis, the pneumonia is there to stay, and to run its course, and no amount of drugging will avoid it. It is absurd to say that a patient would have had pneumonia if certain large doses of quinine has not been administered promptly. How can pneumonia or typhoid fever be predicted before it has arrived? It is difficult to imagine that when typhoid fever or pneumonia is sufficiently fixed in the human economy to enable the physician to make a diagnosis that it can be shaken out by a few doses of quinine or other medicament.

Even before the question of diagnosis is settled there comes an important consideration. That is, not to mask the diagnosis by instituting vigorous treatment too soon. It is not probable that vigorous measures of treatment will be demanded before the diagnosis is fully settled. Frequently cases are treated for malarial fever with large doses of quinine until, much to his embarrassment, the physician is forced to change his diagnosis to typhoid fever just in time to have the certificate of death properly filled out. Added to the probability that if the administration of the quinine had been postponed a little the diagnosis would have been made early, is an equally strong probability that if the quinine had not been given at all the patient's chances for life would have been materially improved. If the teaching of works on Therapeutics are worth anything, it certainly gives quinine little more place in the treatment of typhoid fever than morphine would have in the treatment of opium narcosis.

Quinine acts strongly on the nervous system, and by its use all the nervous symptoms are intensified. When we hear a doctor say that he has made a diagnosis of typhoid fever by "carefully eliminating the malarial element by the use of

quinine," we can predict with reasonable certainty that his typhoid case will be one with intensified nervous symptoms. A very common error in diagnosis is to fail to differentiate malaria from typhoid fever. It should be rare that a case of typhoid fever is diagnosticated as malarial fever. Malaria should not be used as the shield for our mistakes. The risk to our patients is too great. It is far better to say the disease is not sufficiently developed to make a diagnosis. Above all do not try to force a diagnosis by the use of quinine, for we will certainly do harm if the case proves to be one of typhoid fever.

Let us look for a moment at the general characteristics of acute self-limited diseases. In the first place, we have a person previously healthy, stricken down by an acute onset of disease, having been preceded by premonitory symptoms more or less pronounced. Then follow all the symptoms of an inflammation. These diseases are variously named according to the seat of inflammation. There is fever as a constant factor in all. The tendency of all is to run a definite course and to end in recovery. There is an inflammatory lesion of which the producing cause is the same in every case of the same disease. Modern researches would lead us to believe that every disease of this class has a specific organic cause, and further, this causative agent is *similar* in all these diseases.

We should always bear in mind that a fatal result follows in only a small per cent. of cases, and always from one of two causes—either there is some complicating element in the case, or there is such an intensity of the poison from the first that a fatal result is almost inevitable. The toxic principle is forced into the system in such quantities that all the vital functions are overwhelmed and overcome in spite of all efforts to assist in eliminating the poison and to sustain the patient. This is peculiarly true of pneumonia. Frequently cases are seen in which the lungs fill up so rapidly, and the general disturbance is so great, that the patient is carried away by the intensity of the disease process.

The fatal cases of typhoid fever are more frequently the complicated ones; but still all have seen cases, which, from the beginning, seemed almost certain to terminate fatally on account of the intensity of the process.

In considering the treatment of these cases the first thing which engages our attention is the question of specifics. Do we possess any specifics for any or all of these diseases? Almost every drug in the pharmacopœia has been accredited with some specific action in one or more acute diseases. But still we will be tolerably safe in saying there are no specifics for these diseases, and in the very nature of things it seems almost impossible that there should be. The proof that several of these conditions are of germ origin, and the inference that all the others have similar causative agents, has given a clue to the group of remedies among which to search for specifics.

After the germs of typhoid fever have been implanted in a patient and have developed sufficient activity to enable us to make a diagnosis, it is probably too late to apply specifics. The use of salicylic acid in rheumatism and mercury in syphilis probably approach more nearly specific remedies than any we know, and yet there is much doubt whether they really cut short an acute attack of rheumatic fever or syphilis when these are once well established. Still the acute symptoms of rheumatism often seem markedly modified by the salicylic treatment. Of course, the specific action of quinine in malaria is beyond dispute.

Thus it seems tolerably well settled that, with very few exceptions, it is beyond the power of the physician's art to cure diseases. The doctors of past generations cured diseases. To-day it is a question whether it is within the reach of the healing art to *cure*, except in comparatively few instances. Even in so simple a thing as opening an abscess we only do that which nature was trying to accomplish, and thus, by assisting the natural process, hasten the reparative process. The broadest usefulness of the physician is found in watching closely the efforts of nature, studying the methods by which she is trying to effect a cure, and rendering such assistance as will be useful. Above all, we should be absolutely sure that we do not *interfere* with nature's plan and retard it, thus doing harm.

It would seem that the general and promiscuous use of antipyretics and remedies which have marked depressant effect on the circulation must be harmful, and retard and endanger the final favorable conclusion of acute disorders. The general

use of veratrum, aconite, and the coal-tar derivatives in pneumonia illustrates this thought. The thing most to be feared in this affection is a sudden failure of the heart's action. The best authorities agree that veratrum acts by its power to paralyze the heart muscle and the vaso-motor system of nerves—that it is a cardiac poison and also a respiratory poison. The use of veratrum in pneumonia would not seem desirable as a routine practice, however valuable it may be in the onset of certain selected cases.

That there is a very large amount of useless medication in vogue in the treatment of these diseases, seems evident; and that some plans of treatment are actually harmful is more than a possibility. Of course experimentation in the effects of therapeutic agents is necessary to the advancement of medical science, but such experimentation should be coupled with accurate observation. Empiricism should not be confused with experiment. Our first consideration should be for the welfare of the individual patient. Since, when our case is once established, we cannot abort it and have no specific agents with which to combat it, our first object should be to look well to all the general conditions of the patient and his surroundings. Such considerations as the bath, spongings, diet, hygienic measures, climatic influences and the like should be thought of first. Put the patient in the most favorable condition to resist the disease. The public must be educated to expect more wholesome advice and less useless drugging. Let us remember that much of the medication in vogue is a matter of fashion, and changes almost as rapidly as the seasons. The truly scientific advances in medicine never change, because they are founded on truth and not on theory.

Where is the dreaded plague which once devastated vast populations? Science has stamped it out with its agent—hygiene. How is it that cholera and yellow fever do not spread like the prairie fire and destroy thousands of our inhabitants as they used to do? Science has fenced them in with its agency—quarantine. How is it that cases of small-pox appear but do not spread their contagion to our communities? Science has placed its shield, vaccination, about us. What has become of puerperal fever, with all its dangers to life and home and happiness? Science has sent its agent, asepsis, to prevent it, but if it

should appear, has given us the agent, antiseptics, with which to control it and stamp it out.

These are a few of the posts which stand out prominently to mark the real progress of the last few years in the management of disease. These advances have nothing to do with the giving of drugs, but are infinitely more important. Not that we think for a moment of abandoning the use of drugs, but they should not be considered *all-important*. Do not despise such advice as fresh air, good light, clean linen, the bath, quiet rest in bed, comfortable, quiet surroundings, nutritious but appropriate diet, and attention to the excretions and secretions. It will be the exceptional case of an acute, self-limited disease which will really demand the administration of drugs when all the general conditions are fully attended to. We know that when the disease is established there is little in our art that will affect it directly, except as we observe what nature is trying to accomplish, and render assistance or remove obstacles which lie directly in the line of her efforts. Certain symptoms may be modified and the strength of the patient conserved by well-chosen measures which will assist nature in her efforts.

The largest field of usefulness in the future is to be found in warding off disease by sanitary protective measures and by securing individual immunity. It is hoped that the discussion of this subject will bring out more in detail the usefulness and uselessness of the measures and agents in popular use in this class of disease.

We have few remedies which are definitely shown to be useful in acute self-limited disorders, and there is little general agreement among authorities as to what measures will be found beneficial. One author recommends an agent, another author of equal standing condemns it. Much of the present treatment is empirical, and not founded on any reasonable physiological or even experimental basis. While we are trying to find remedies which will do good, we must remember to be sure and do our patient no harm. Recognize the power of nature and assist her, for, if her efforts are seconded judiciously, she will allow few to die.

The following quotation from a well known authority (Herrmann Nothnagel, of Vienna, *Popular Science Monthly*, May, 1892,) is full of meaning:

"Although the expectation and the possibility of controlling the fundamentals of pathological processes are so limited, the healing art is nevertheless not doomed to vain contemplation and inactive dallying. While art cannot master nature, it can follow it with diligent observations. The truth of this remark covers a genuine progress and furnishes the key of the success of really great physicians. To investigate the exact origin of pathological changes; to ascertain by what method and under what conditions disturbances of the organism are most easily overcome and counterbalanced; deliberately to support and imitate these methods if possible; and, before all, do no harm, is the way by which the healing art can accomplish something important and good. History proves incontestably that practical efficiency at the sick bed goes in an exactly parallel line with the cultivation of scientific methods. Medicine to-day, without yet being able directly to cure the pathological condition, reaches, simply by following the principles here laid down, incomparably more favorable results than formerly. It has learned, first of all, not to interfere so as to destroy the course of natural compensations, but seeks by dietetical, hygienic and climatic influences here, by the removal of excitants there, by methodical stimulations of the matter-changes of the nervous system, to put the organism into a condition to overcome the pathological disturbances. To use such measures, carefully adapted on principles of scientific observation and enlarged knowledge of the course of disease to the most diverse conditions, continually to furnish a closer support to the natural compensations and adaptations, that is one of the ways in which the healing art must turn in order to enlarge its scope."

MODERN TREATMENT OF EMPHYEMA.

By D. A. K. STEELE, M. D.,
CHICAGO, ILLINOIS.

PROFESSOR OF PRINCIPLES AND PRACTICE OF SURGERY
AND CLINICAL SURGERY IN THE COLLEGE OF
PHYSICIANS AND SURGEONS, CHICAGO.

The great increase in the number of cases of emphyema during the past year or two, is a sufficient reason for considering the best methods of dealing with this surgical affection.

The greater frequency of pleural abscesses is probably due to the saturation of the blood with bacterial germs of recurring epidemics of influenza.

By empyema we mean a collection of pus in the pleural cavity; bounded on one side by the soft, receding, compressible lung, and on the other by the firm, unyielding, bony chest-wall.

In the consideration of its surgical treatment we follow the lines laid down by Immerman, of Basle:

First, to evacuate the pus.

Second, to prevent the formation of more purulent matter.

Third, to restore the respiratory apparatus to its normal condition.

To accomplish these three objects a great variety of surgical procedures have been devised. In a paper presented to the surgical section of the thirty-ninth annual meeting of the American Medical Association, held in Cincinnati, May 10, 1888, I classified the choice of operations as follows:

First, aspiration.

Second, aspiration and washing out of the cavity with an antiseptic solution.

Third, thoracentesis with trocar and canula.

Fourth, thoracentesis with subsequent drainage.

Fifth, simple incision.

Sixth, simple incision and drainage.

Seventh, simple incision, with through and through drainage, with or without antiseptic precautions.

Eighth, subperiosteal resections of rib and drainage.

Ninth, thoracoplasty—Eslander's operation.

Tenth, perfation.

Greater experience with these different methods enables me to say that aspiration for diagnostic purposes and to afford temporary relief to the patient, followed by simple incision and drainage with antiseptic irrigation and the application of an antiseptic dressing, constitutes the modern method of treatment of empyema. In some cases where the ribs are too close together to afford room for the drainage tube, or where its presence produces neuralgia from pressure upon the intercostal nerves, the subperiosteal resection of a rib must be resorted to, although it is seldom that I have found this procedure necessary.

In regard to the technique of the operation I would say, that the simplest, speediest and safest plan of operation is the best. The one that subjects the patient to the least additional risk of shock, pain, or time of operation should be selected.

Time of operation.—The operation should be done at the earliest possible moment after a diagnosis of a collection of pus in the pleura has been made; nothing is gained by delay and much valuable time is lost. The strength and vitality of the patient are jeopardized.

Anæsthetic.—Local anæsthesia by hypodermic injection of a five or ten per cent. solution of muriate of cocaine, or by freezing the site of operation with an ether spray, is greatly preferable to the use of a general anæsthetic, especially where there is a large collection of pus, or where the heart has been displaced.

Site of Incision.—The incision should be made in a location that will most perfectly drain the pleural cavity, whether the patient is lying or sitting.

These requirements are best met by an opening in the vertical line below the posterior fold of the axilla, between the sixth and seventh ribs on the right side, and between the seventh and eighth ribs on the left side. Of course, various modifications of the site of the incision are required for special cases.

Two plans of making the incision are open to us: either to pinch up a fold of the skin with thumb and finger at the point indicated and transfix it with a sharp-pointed bistoury, thus leaving an incision of two inches in length down upon the intercostal muscles, which are quickly separated by dissecting forceps and the bulging pleura punctured with sharp-pointed scissors or director, along which the drainage tube, grasped by a pair of forceps, is pushed into the abscess cavity; or you may push the index finger of the left hand down between the ribs at the point selected, and alongside of it introduce a grooved exploring needle, and along the groove of the exploring needle push a narrow, blunt-pointed bistoury and make a two-inch incision midway between the ribs through the entire thickness of the chest-wall, and introduce your drainage tube. I prefer the first method, although both are done very quickly and safely.

A double tube should always be introduced, so that you can throw a stream in one tube and have the return current flow out of the other. The tube should not exceed one-third or one-half inch in diameter, and only the return tube should have lateral perforations. There should be a free opening at the inner extremity of the tube. This is easily obtained by bending the tube upon itself and cutting off half the thickness of one side of the bent tube. An ordinary safety-pin holds them well in position.

Andrew's tube is too large for the majority of cases. Hancock has recently fused two tubes together and fitted over them a rubber plate or collar which is a decided advantage.

After thorough irrigation with a warm antiseptic solution until the water returns clear, the wound around tubes is covered with iodoform gauze and a moist dressing of bichloride gauze ten or twelve thicknesses surrounded with salicylated cotton, is applied and kept in place with a flannel roller. The dressings should be changed and the cavity irrigated daily for the first week, and thence every other day.

The strength of the solution may be bichloride of mercury 1 to 8,000 or carbolic acid one per cent., or Labarraque's solution, one to twenty, which latter is the safest.

The temperature of the water should be 100° to 105° and the quantity for each irrigation should be at least two gallons.

The time of treatment required under this plan is from two to six weeks.

It is not necessary to wait until the cavity is completely obliterated before the tube can be removed, but when for several days there has been an absence of pus, and the discharge consists of a small quantity of colorless, odorless serum, the tube may be removed after a thorough irrigation, and the cavity sealed up. It is possible to disinfect and sterilize an old septic cavity where old adhesions prevent its obliteration by approximation of the lung and chest-wall, and then seal up a clean cavity of large size and have no further trouble from it.

I believe in the majority of cases tubes are left in too long and irrigation continued too persistently, and that it is possible for us to materially shorten the duration of treatment of empyema cases.

SOME SUGGESTIONS ON INGUINAL HERNIA.

By W. M. HARSHA, M. D.,
CHICAGO.

Considering the prevalence of inguinal hernia, the frequency with which strangulation occurs and the dangers that attend it, we may well be surprised at the want of interest manifested by the profession generally in its prevention and treatment.

Among the most potent predisposing causes are hereditary muscular defects and lengthened mesentery. With these, little can be done in the way of prophylaxis.

Among the most frequent exciting causes, especially in the young, where most cases occur, are constipation and phimosis. These are conditions that may be remedied. Strict instructions to nurses in regard to the management of infants may prevent many cases of hernia. The practice of giving soothing syrup or other opiates often induces a constipation that may cause a hernia. The use of castor oil may be followed by a secondary constipation. A small enema is often all that is needed to move the bowels, and the mildest means which will suffice are to be urged, especially in families predisposed to rupture. The neglect of a phimosis has been a frequent cause of hernia, as is well known. The treatment of the phimosis is demanded from other considerations as well. The longer the conscientious physician practices his profession the more he feels the responsibility of his position; and the neglect of anything that may cause a hernia may prove a disagreeable memory to the physician as well as a source of mortification and danger to the patient.

After the hernia has occurred we have a foe worthy of our steel and we should not send the case to a truss-man at random. There are conscientious and skillful instrument-makers who try in a rational and intelligent manner to treat each case on its merits, but the majority of these men have a favorite truss or appliance, as they may be pleased to term it, with which they profess to treat all cases successfully.

Directions given in text-books are often vague and leave much to the judgment of the surgeon. In congenital cases not

infrequently the management of an undescended testicle is involved in the treatment, where a nice adjustment of a small pad may be a necessity. Again, we may have a case of long standing where the rings are approximated and present the appearance of an opening straight into the abdomen directly above the pubic bone. In such cases a hard pad with the pressure in the right place will injure the cord, while over the usual site of the internal ring it is wide of the mark. Such a case I have found best-managed by means of a soft rubber pad filled with water, which may press close to the pubic bone, retaining the hernia, but sparing the cord. It is my belief that a majority of cases in children may be cured in a reasonable time by properly selected and adjusted trusses, if the same care and attention be given to them that other surgical cases no more important command. Our duty is not done when a truss is adjusted. We should keep the case under observation and note the progress, or lack of it the same, as we would in a case of spondylitis.

Operations of a radical character are not often to be recommended in the young except when strangulation occurs. The different character of the sac in many cases of congenital hernia and the lack of intelligent co-operation on the part of the patients contra-indicate operation as a rule. However, where the rupture is not retained by a truss and where conditions tend to grow worse, I think it our duty to treat them by operation.

My experience with the injection method in children does not encourage me in its use. In some cases, both of children and adults, I have used it successfully, especially where the opening has been small, the hernia reducible and the canal not obliterated by long distension. I have used the injection as recommended by Warren, of Boston, the fluid composed mainly of a concentrated fluid extract of white oak bark. The injection method has, however, been well characterized as blind surgery, and can be recommended in but a limited number of cases.

Since aseptic surgery has come to us, open operations are comparatively safe when done in the absence of strangulation, and we believe will become more frequent in both children and adults. Considering the very high death rate from strangulations and operation for relief, it seems strange that operations should be so rare

in the absence of strangulation, or so late when it is present.

There are many cases of hernia, that are not well retained by trusses, that are painful and constitute a constant source of danger, in which operation should be advised.

In the conduct of the operation the first requirement is absolute asepsis so far as that is possible.

If there has been much distension of the skin and subcutaneous fascia, enough of the redundancy should be removed to secure a smooth and somewhat tense covering. The incision recommended by Dallas, of New York, commends itself to me. It is begun above the pubic bone and carried straight outward beyond the canal, then straight upward. The triangular flap is then dissected up and reflected, exposing the field of operation. Incision is now made along the direction of the canal through the deeper structures down to the sac in the usual manner.

The sac is next treated according to the individual preference of the surgeon, but should be cut off close up to the internal ring, or treated in such a manner as to prevent any protrusion or pouching.

Buried animal sutures should be used as recommended by Marcy, of Boston, throughout the extent of the wound along the canal, in order to get the most firm union. The flap of skin and fascia may now be stitched in place, preferably, I think, by silk-worm gut, tied as advised by Treves, i. e., using only the first part of the ordinary surgeon's knot and left lying flat on the surface. If much tissue has been resected a tension suture may be used.

The edges being easily approximated, may be painted over with flexible collodion, saturated with iodoform, and an antiseptic dressing placed over the whole. Union by first intention, may be expected throughout, and if it is thought best to wear a truss afterward, it can be adjusted so as not to be directly over the cicatrix as in the ordinary operation. In a majority of cases I believe a truss, with only moderate pressure, should be worn for a time, as I think the danger of pressure atrophy very slight. The frequency of ventral herniæ after laparotomies shows the necessity for precaution in any operation involving the abdominal wall.

In calling attention to this subject I wish to emphasize the following points:

1. That hernia in children may frequently be prevented by strict instructions to the nurse, or by operating to cure a phimosia.

2. That hernia having occurred, a persistent effort should be made to effect a cure by means of suitably adjusted trusses while the child is in the growing stage.

3. That failing to effect a cure in that way in due time, and especially failing to retain the hernia, an operation should be advised—usually the open method.

4. That in adults where retention is difficult and uncertain, and the patient made uncomfortable or disabled, an operation should be advised in the absence of strangulation, and an early operation in case of strangulation.

5. That after operations it is better to wear a truss or some sort of support until adhesions are firm.

THE TREATMENT OF TUBERCULAR PERITONITIS.*

By WILLIAM H. MYERS, M. D.,
FORT WAYNE, IND.

"My Uncle Toby" considered that the secret of human happiness lay in the possession of a soul-satisfying hobby. If his idea was correct, then it has been our good fortune to be happy since 1821, at which period Drs. Graves and Stokes, of Dublin, first directed attention to the use of opium in the treatment of peritonitis. Afterwards under the teachings of Dr. Clark it assumed considerable permanence and predominated over all other treatment and was regarded as curative. This period constituted the opium habit of the profession. At present we have a progressive invasion by the surgeon of this once purely medical region. Inertia in the profession is passing away. Professors and authors are no longer followed by us, with a punctuality equaled only by the old order of monks, about penance and absolution. We are just now emerging from the doctrines of the living ancients, that opium, alcohol and liquid diet is the treatment

for peritonitis, whatever its cause, and whether it be general, circumscribed, diffused, septicæmic or tubercular. If there be those present who endorse this treatment under all conditions then I can only say, "God hath not justly dealt by them," for a correct diagnosis with a correct apprehension of the etiology of each case must suggest a different line of treatment from that mentioned. We assert that it is only through a perfect diagnosis that we can see when and how therapeutical or surgical measures must be attempted. Upon this all correct treatment must depend. It is also of primary importance that the etiology be definitely settled at the earliest moment. "We must learn the beginnings of disease" as remarked by Sir Wm. Gull: "Often when the gathered clouds of the final storm have filled the atmosphere, it is in vain that we look around to see from what part of the heavens it began." When we have arrived at the conclusion that peritonitis is present, and have discovered the cause, the blow must be struck simultaneously with the onset. No delay can safely be tolerated, the only hope of rescue being the sudden arrest of the disease, for in the language of Hutchinson, "it is almost impossible to exaggerate our conception of wild-fire rapidity with which inflammation of the serous membranes may extend when once an adequate cause has been supplied. By the time that the normal outlines of the abdomen are obscured by tympanitic distension, respiration quickened and shallow, the pulse rapid and wiry, the supreme moment for precise diagnosis is passed."

I need hardly remind you that the greatest advancement made in the surgical treatment of disease, was the result of investigation by abdominal surgeons into the tolerance of the peritoneum; this led to new lines of research and from them have resulted a complete revolution in peritoneal surgery. They soon discovered that idiopathic peritonitis was only found in the text-books and not in the abdomen. Passing from this to the subject of our paper, we may quote the language of Dr. Osler, that "abdominal section for tubercular peritonitis is the most recent triumph of surgery." At the last meeting of the American Obstetricians and Gynecologists, I reported two cases of tubercular peritonitis treated by abdominal section, washing out the abdominal cavity and drainage,

*Read before the Southern Surgical and Gynecological Association, Nov. 15-17, 1892.

with complete recovery. Since then I have operated upon another case, apparently with a like result. All these cases were males, with ages ranging from twelve to twenty years. In the last case adhesions were extensive, between the bowels, accompanied by tubercular deposits, and a strong band of lymph thrown across the colon in the right iliac fossa, causing obstruction and was believed to be a case of typhlitis. The diagnosis was only made clear by the laparotomy; there was present only a moderate amount of fluid. The enlargement of the abdomen was due to numerous deposits in the mesentery. The body was emaciated. This case evidently belonged to the adhesive form of the disease, and this accounts for the irregular and impeded peristalsis or intermittent obstruction of the bowels, it being the most prominent symptom.

The chief interest in these three cases is the bearing they have upon the treatment of chronic tubercular peritonitis. Let us contrast the result of surgical treatment with medical treatment. Under the latter the prognosis had been so grave as to preclude the possibility of holding out to the patient the least hope of recovery. Loomis, one of Clark's disciples, says: "The treatment of tubercular peritonitis demands small doses of opium, warm anodyne applications, tonics and cod-liver oil." His prognosis he states as follows: "Tubercular peritonitis after weeks and months of anæmia and exhaustion, terminates in death." Davis under the subject chronic peritonitis, says that "all cases arising from tuberculosis are incurable, temporary relief may be obtained by removal of the accumulated fluid by aspiration or tapping, but the diseases which have given rise to the peritoneal trouble being themselves incurable, there is an inevitable tendency to a fatal termination." Bauer, in Ziemssen's *Cyclopedia*, regards the prognosis as absolutely fatal; the same opinion is expressed in *Pepper's System of Medicine*, and Fagg speaks gloomily of the issue. So if we trust medical writings on the subject, recovery from this disease must be considered rare and exceptional.

Curability by Operative Treatment—König, of Göttingen, gives an opinion founded on 131 cases, that by laparotomy 95 per cent. are much benefited and 25 per cent. completely cured. Manoange

supplies us with 68 cases, of whom 13 died soon after operation, 15 disappeared, 14 remained alive at the end of six months and 26 at the end of twelve months. Homans records two cases with recovery. Goodell has operated on four cases; three recovered and one died in six months after the operation. Mundé has operated in three cases with one death and two recoveries. Kelly gives four cases and four recoveries. Imbach mentions five cases on which he had operated, with four recoveries. Grieg Smith has operated on two cases with one death. Pitts has operated on three cases and all made good recoveries. In a report of 112 cases the results may be stated as follows: One was unrelieved, 26 apparently recovered; 28 died soon after the operation, 57 made a more or less complete recovery—nearly 50 per cent.

In support of this new departure, I present the following quotation from a recent author: "Though it seems that the surgical claims are extravagant, I nevertheless, believe that in the routine treatment of tubercular peritonitis, recourse should be had to surgical means, both more frequently and at an earlier period than is commonly the case." Hare, in his recent work, speaking of two opposing factions in the profession, the one addicted to salines and the other to opium, claims the first-class dogmatically assert that the physician should turn over every case of peritonitis to the surgeon, to be opened, searched and purged, and he further asserts that too many cases of peritonitis are to-day walking examples of the value of the use of opium to permit anyone to assert that this treatment is useless.

In reply to this argument, I need only say that "walking examples" are referred to every day to attract the credulous, to crowd the consulting rooms of charlatans, who trade upon the discoveries of science to palm off their monumental proofs of success.

Diagnosis.—Called to a case, upon what symptoms, objective or subjective, can we rely as authorizing an abdominal section? The presence of tubercular peritonitis may be inferred if pain in the abdomen resembling colic and tenderness often recur with diarrhoea and febrile excitement present only temporarily; subsidence of these symptoms and the patient relieved, and in a few days again recurring, possibly in an aggravated form, and accompanied by a

mass detected in the umbilical, hypogastric, or iliac regions; the body wasting at the same time, while the abdomen remains large, often tympanitic, and with less of its suppleness; there may be detected serum or lymph and the difficulty of promoting absorption by the usual remedies, may be considered. In this discussion we have limited tubercular peritonitis to those cases in which the peritoneal affection predominates,—essentially an outbreak of gray miliary tubercles upon the peritoneum, from which inflammation of this membrane ensues. The disease presents itself in one uniform process, but with different stages; the ascitic, the suppurative and the adhesive. The first is the earliest stage; its product is serum. In the second stage we have pus, the product of the inflammatory action. In the third, adhesions due to the presence of lymph thrown out, the bowels agglutinated thereby and obstruction resulting therefrom. Now, gentlemen, the treatment must suggest itself to you. In the ascitic form to remove the fluid; this is essential to recovery; here the trocar and aspirator as curative procedures are abandoned and relegated. I would strongly impress upon you the free use of the knife. This has happily been substituted with the highly satisfactory results already referred to. In the second variety—suppurative—we know of no reason why the same general principles of treatment by surgical interference—the early evacuation of pus—should not be carried out. In the adhesive form, as its name implies, adhesions will be found between the intestines and possibly the parietal peritoneum; here obstruction of the bowels, often incomplete, accompanied by distension is often present. These cases are often latent and the pathological lesion is only revealed by an operation. The operation needs no especial description, only the suggestion of extreme caution, to open the abdomen freely, and to remove fluid lymph and caseous material as completely as possible, and not to depend merely upon the withdrawal of the fluid, the ancient method which is here considered “more honored in the breach than in the observance thereof.” I would further advise the avoidance of germicidal solutions, to use hot water instead, to use drainage, and that the after dressing and after treatment be managed in the usual manner.

Communications.

RUPTURE OF THE STOMACH.*

By JOHN W. GROFF, M. D.,
HARLEYSVILLE, PA.

Traumatic rupture of the stomach without injury of adjacent organs is, I presume, a rare occurrence. Such a lesion, verified post-mortem, leads me to present the following case to this society.

A farmer, F. B., Aet. 50; a German, residing in this country but a few years; married; above the average in height; of strong muscular development; temperate, industrious and exceedingly frugal in his habits. On the day of the accident, immediately after breakfast and while gearing his horse, he was kicked by the animal, receiving the full force of the blow directly over the region of the stomach. He was able to reach the house, a distance of perhaps 150 yards, where I saw him an hour and a-half after the accident. I found him in bed, lying upon his right side with his extremities drawn up, and in the utmost agony. Occasionally he would vomit but the material was ejected without any force. There was no external evidence of injury visible save a few drops of blood in the umbilical fossa.

Shock was profound, and the pulse at the wrist was barely perceptible. Upon making a hasty examination I concluded he was mortally injured, and beyond the reach of human endeavor. Hence, the only object to be aimed at was the production of euthanasia. A prognosis was given accordingly and our efforts directed to making him as comfortable as possible. I gave him at once a hypodermic injection of morphia $\frac{1}{4}$ gr., atropia $\frac{1}{16}$ gr. In half an-hour gave a second injection of $\frac{1}{4}$ gr. of morphia, followed in thirty minutes by a third injection of $\frac{1}{4}$ gr. of morphia. These were followed by a fourth injection at the end of another half-hour, when he became comparatively quiet and the vomiting ceased. The pain was not completely relieved at any time.

Dry heat was applied to the extremities and I left him to return in about five hours. During this interval reaction had occurred and the mortal nature of the injury was still more evident. He lin-

*Read before Montgomery County Medical Society, November 2, 1892.

gered, however, and died sixteen hours after receiving the injury.

Autopsy by Dr. H. F. Slifer sixteen hours after death. Upon opening the abdomen the contents of the stomach were found free in the cavity. Careful examination of the whole length of the intestine showed no injury whatever. He found in the stomach a large irregular opening, about two inches in length, transverse to the lesser curvature, more on the anterior surface and nearer to the pylorus. All the coats of the stomach were divided completely excepting a few thin meshes of the serous coat still remaining over the wound. The omentum was deeply congested, as were the neighboring parts. There was considerable serous effusion in the abdominal cavity, also an increased amount of fluid in the pleural sac and in the pericardium. No free arterial blood had been noticed in the vomited matters. There were evidences of old pleurisy, but no other organs showed noticeable evidence of pathological change.

[This report, necessarily condensed, is of interest on account of the character of the injury and the method of treatment pursued. Possibly a different result would have followed more active measures.

The condition of the patient—shock, pain, *forceless* vomiting, history of the accident, etc., seems to point definitely to the location of the injury and to suggest, at least, one of the organs involved. *Ante-mortem* section of the abdomen would have confirmed the diagnosis and perhaps, avoided this performance *post-mortem*. It certainly would not have hastened it. Repair of the opening, in the stomach, flushing the abdominal cavity with hot water and closure of the abdominal incision, with provisions for drainage, if they did not prevent the final result would have been more productive of *euthanasia*. The probability of a satisfactory outcome is indicated by the fact that, in spite of the injury and the treatment, the patient lingered sixteen hours. —Ed.]

FOR COLDS IN THE HEAD.

R Hydrochlorate of cocaine.....	2 grains.
Menthol.....	4 "
Boric acid.....	30 "
Finley powdered coffee.....	8 "

M. Sig.: Take in pinches five or six times a day.

—Chem. and Drug.

Society Reports.

THE LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.

Stated Meeting of November 4, 1892.

THE PRESIDENT, DR. F. C. SIMPSON, in the chair.

OBSTRUCTION NEAR INNOMINATE VEIN.

DR. C. W. KELLY: Doubtless many of you have seen this patient, Thomas Welsh. He has been in the City Hospital during the past year. He was first in the Surgical Ward under the care of Drs. Yandell and Rodman. After examination he was sent to the Medical Ward and came under my care. I examined him and found obstruction to the flow of blood through the superior vena cava, the obstruction being located near the vena innominata, the heart being free from disease; the veins in the neck, face and arms were much distended and on the least exertion the face and arms would turn purplish black. I lost sight of this man three months ago, at which time, upon making an examination, I found the veins on the side of the trunk very large, the long thoracic and deep epigastric veins being fully the size of the index finger, the right being larger than the left. It was found that the current of blood was flowing from the head, neck, arms and trunk through these channels down to the inferior vena cava by the iliac veins; this could be very easily proven. A case like this I have never seen before. This man received an injury about a year ago, caused by the fall of a telegraph pole upon his head. However, I see no connection between the injury and his present trouble. He has suffered from an attack of pleurisy, affecting the left side. I suspect the obstruction has resulted from an inflammation, either of pleura or of tissues near the superior vena cava.

DISCUSSION.

DR. W. L. RODMAN: I would say that when this man came to the Hospital, a year ago last September, he was sent into the Surgical Ward. I was visiting surgeon at the time. After making a very careful examination, and from the history of the case I reached the conclusion that the blow on the head could not have had anything to do with the trouble, and referred him to the Medical Ward.

DR. F. C. WILSON: The practical question is, what can be done, or whether anything can be done for him. The case seems to be progressing; I recollect seeing the patient over a year ago, and there has been considerable increase in the distressing symptoms since that time. The trouble seems to be gradually increasing, and I would like to inquire what has been done, and what the prospect is for doing anything for him. If the trouble is due to some inflammatory deposit an effort should be made to absorb this. Possibly iodide of potassium or bichloride of mercury would be of benefit, as these agents are known to produce good effects upon inflammatory exudates. I do not know whether any methods of this kind have been tried or not.

DR. C. W. KELLY: Concerning the suggestion made by Dr. Wilson: This man was given iodide of potassium and the mercurial agents in large doses continued for six months, without any apparent benefit. I think nature is doing more for him than anything else could possibly do. His only hope of long life evidently is through the enlargement of these channels that are being opened up.

STRICTURE OF OESOPHAGUS—PATHOLOGICAL SPECIMENS.

DR. W. L. RODMAN: This specimen is the stomach and oesophagus removed from a man at the post-mortem examination. The history of the case is about as follows: German, forty-seven years of age; I found him in the Surgical Ward at the City Hospital when I went on duty about two months ago. He gave an uncertain history of syphilis to some of the physicians, but from what he told me I think he had an attack of gonorrhœa; he said he had a discharge from the urethra some ten or fifteen years ago. For eight months prior to the time I saw him, he had marked symptoms of stricture of the oesophagus. His oesophagus was carefully examined and the stricture located just below the thyroid cartilage. At the time I saw him he was unable to swallow even a drop of water; he had taken no food for two or three weeks; he was suffering the pangs of hunger; was going down hill all the time, and we commenced giving him enemata of milk and brandy. He improved very much for two

or three weeks, really gaining a little flesh, and said that the enemata we gave him daily relieved his hunger and he was made far more comfortable by them. As he was doing so well, we thought we would hold him until we moved into the new Hospital. Then we intended to do a gastrostomy. As I said he was improving on the rectal feeding, and for two or three weeks gained flesh, he was able to be out of bed and worked around the Hospital. I was very much surprised to find, on going to the Hospital one Monday morning, that the man was dead. I was told by the *interne* that the patient had developed diarrhœa on Saturday, the bowel refusing to retain the enemata any longer, and died on Monday morning before my visit.

This is a very interesting case: The stricture is so complete that you cannot get anything through it at all. I saw the man make four or five attempts to swallow some water, not a drop of which passed the stricture, judging from the amount that returned. The stricture is just about where I thought it was, a couple of inches below the thyroid cartilage. When I saw him he said the first symptom he had of stricture was eight months previous to that time; now the stricture was complete. The man had taken large doses of mercury and iodide of potassium which did no good.

I suppose it must be stricture as a result of traumatism. I do not think it was the result of a neoplasm, although this was my opinion at the time. It does not look like an epithelioma; there is no apparent history of traumatism; no history of his having swallowed caustic of any kind. I believe now that it resulted from simple ulceration, the result of trauma.

DISCUSSION.

DR. A. M. CARTLEDGE: It strikes me as being a remarkable stricture of the oesophagus; it does not present the appearance of a malignant or syphilitic stricture which we usually find; I say this from the simple appearance, although the stricture is a very severe one and is probably due to trauma originally; due to something he swallowed, causing ulceration and a resulting cicatrix.

DR. WM. CHEATHAM: I saw this patient during my term of service at the hospital, and never saw a man improve so

much under rectal feeding. I tried both the bougie and œsophagoscope and each marked different depths of the stricture. I have used the œsophagoscope on several cases of stricture very successfully. I had a case a few days ago complaining of stricture three or four inches down, which the œsophagoscope showed to be spasmodic in character. This instrument can also be used to good advantage on growths in the œsophagus. The only objectionable feature is that the patient has to be choloformed and put in an exaggerated tracheotomy position, the head at almost right angles with the spinal column, to introduce the instrument. I tried it on an old man, and found it could not be used, because his neck was too stiff.

DR. W. O. ROBERTS: I agree with what Dr. Cartledge has said; it looks very much like a case of stricture, the result of trauma. I have just been to see a young lady who was brought here two weeks ago from a distance. While at a party she said she swallowed a bone, and it lodged in her throat. This was on Saturday, two weeks ago. I saw her on the following Monday with the family physician and another gentleman who pays particular attention to throat surgery, and made a careful examination, but could find no bone in the œsophagus. The following Monday she suffered more and her suffering continued to increase, her throat began to swell on the outside, and last Monday she had great difficulty in swallowing liquids, (from last Monday week until last Monday), then ceased to be able to swallow at all. I examined her this evening, found her temperature $101\frac{1}{4}^{\circ}$ F. She has not taken anything into her stomach since last Monday; both sides of her neck badly swollen, extending nearly up to the angle of the jaw, and on the inside I detected a post-pharyngeal abscess, a little to the left of the center, in which is undoubtedly fluctuation.

DR. C. SKINNER: I will report a case in the same line, showing how a man was relieved. About four weeks ago a man came to me from Pineville, having been unable to swallow even water for about forty hours. I tried different sized tubes and could get nothing to pass, and sent him over to the Infirmary with the expectation of going back later in the afternoon and trying it again. Just before my time to go, his brother came over and said he had been able to swallow some water.

He accomplished this by filling his mouth full of water and then forcing it down. I gave him some milk which was swallowed in the same way. I then passed a tube about the size of your finger, and it marked two distinct strictures,—one about one and one-half inches below the other. The tube was grasped very firmly at these points. He went home without any further trouble.

DR. E. R. PALMER: It is very questionable in my mind whether the trouble in Dr. Rodman's case could have been due to syphilis: First, because of the great rapidity of its development, and second, because it should have been followed by very decided amelioration under specific treatment if it were a tertiary lesion. With the uncertain history and the absolute failure of specific agents to have any effect whatever, I should be inclined to attribute the trouble to trauma.

DR. W. L. RODMAN: I accept the theory of trauma. When I made the statement that there was no apparent history of trauma, I meant that he had never swallowed any sulphuric acid, lye or anything of that kind. If there was any traumatism, the patient did not remember it. I think in swallowing some bone it probably lodged for a time, causing simple ulceration, which resulted in stricture.

I am satisfied in my own mind that it is not a syphilitic stricture. In the first place syphilitic strictures of the œsophagus are not so common as some think they are. Then, as Dr. Palmer says, it would not have developed so rapidly if it had been the result of a syphilitic attack ten or fifteen years ago. I questioned the man very carefully when he was brought into the ward, and am satisfied, from the information he gave me, that he had never had syphilis, but it was simply gonorrhœa. He never had any eruption; never had throat trouble; never had enlarged glands; never lost any hair, and I have no reason to suspect that he had an attack of syphilis.

DR. D. T. SMITH: It seems to me in this case, if there had been trauma sufficient to result in a stricture of this extent, the man certainly would have remembered it.

PLASTIC EFFUSION INTO THE PERICARDIUM.

DR. C. W. KELLY: Instead of reading a paper this evening, I will report a case

or two which have come under my observation within the past five or six days.

A week ago last Thursday I was called to see a young man, a medical student, suffering with pain over his heart. When I went into the room, I found him very much excited; his pulse was irregular, and on change of position would increase in radidity. It was found, on examination, that there was a plastic effusion in the pericardium, and its movement to and fro with the heart-sounds could be very easily made out. There was nothing peculiar in this case, no accumulation of fluid in the pericardial sac, and nothing except this plastic effusion.

No. 2: The second day after that, one of Dr. Marvin's patients sent for me in a hurry, the message being that a gentleman was very ill. I called at the house and found another medical student who was suffering from a similar trouble, although it differed in some respects. As soon as I went into the room I heard a peculiar noise. I asked the young man who was in attendance what it was, and he said he did not know, but every four or five minutes we would hear that peculiar sound. I can compare it to nothing but the pulling of wet leather from a smooth stone, a sticky, sucking sound. I was very much interested in this peculiarity and the patient was very anxious. The young man said that Sunday night he went to church and while there had a severe pain, beginning at the scapula and terminating in the lower part of the sternum. The pain was so severe that he became anxious and went home. After reaching home he went to bed, lying upon his back, and found that he could not turn over; the pain continued and a physician sent for. This is about the history of the case.

I asked the patient if he had ever had an attack of rheumatism, and he said that he never had rheumatism or a pain of any kind before. Upon examination I found that there was pericardial plastic trouble, and very strange to say, the heart seemed to have become attached to this body of lymph, that I suppose was poured out into the pericardial sac. The pulse was very irregular,—there would be several beats, then an interval, the heart seeming to stick to the lymph. It ranged from forty to seventy-five beats per minute, and I was very much afraid the man was going to die. He was very much excited. I

found the to and fro friction rale which had been masked by the first or second sound of the heart. I suspected first that it was pleuritic trouble, the heart rubbing against an inflamed pleura; when I asked the patient to stoop forward, I found that the same peculiar sound continued, and I keep him in the recumbent position, perfectly flat. Yesterday the sound was disappearing; no longer that peculiar action of the heart; pulse had become regular; pain decreasing and altogether the gentleman seems to have convalesced. The other case reported is also in the same condition, convalescence seems to have been established in both cases. I have kept these patients perfectly quiet, would not allow them to get up fearing effusion, although to all appearances they seem well enough to sit up. I have never seen a case before where simple effusion caused such interference with the heart's action, and have been unable to determine the cause in either case reported. As I stated there is no history of rheumatism in either case, and both patients have heretofore enjoyed good health.

DISCUSSION.

DR. J. B. MARVIN: I have seen more cases of pericarditis in dead halls than I have recognized during life. I have one or two very pretty specimens of this plastic effusion. I had a very interesting case of this kind, at the city hospital, in a negro boy where there were the ordinary physical signs of pericarditis and an area of increased dullness; from the appearance I thought of course it was effusion, and inserted my hypodermic needle but could get nothing out by it. I repeated this various times and although I had demonstrated effusion, I could not get it out. Undoubtedly the lymph was so thick that it could not flow.

I was interested in one point made by Dr. Kelley, and it is one that I have been investigating carefully for the last few years, namely the relation between endo- or peri-carditis and rheumatism. I have certainly seen cases where I could not trace any history of rheumatism. In cases where there is no subsequent joint lesion, it seems to me rather doing violence to the true etiology to claim that they are rheumatic in origin, and I am satisfied we have been led astray by the older authorities.

DR. WM. BAILEY: From the statements made by Dr. Kelly I understand that these murmurs, so-called, were not synchronous with the heart's action. I would like to know if the Doctor counted the repetition of these for a minute so as to get at what was produced. A fluctuation murmur, pericardial, ought to correspond with the heart-beats, just as an endocardial murmur does, or as the fluctuation sounds of pleurisy correspond with the number of respirations per minute. But it is practically competent, I think, for an inflammation to be in one membrane and one of the other membranes produce a frictional sound. It seems to me the fact that fluctuation did not disappear when respiration was stopped, indicates pericarditis. Pericardial murmurs are, as a rule, communicated to the pericardial space; not transmitted, as endocardial murmurs, outside of that space.

As to the question of rheumatism: I think it is safe to say that the majority of these affections, either endo- or pericardial, are due to rheumatic causes, whether there are any other manifestations or not. Simply to have no joint complication is not proof that it was not rheumatism.

The interesting point in the case reported by Dr. Kelly would seem to me to be to determine whether it was pericarditis or whether it was inflammation of the pleura so closely situated to it, so nearly related to it, that the motion of the heart might cause fluctuation of the pleura; the quick convalescence and the apparent short course of the case, too, might have some bearing upon the location or character of the disease.

DR. WM. CHEATHAM: I would say in regard to the rheumatic element in these cases, we see a great deal of it in inflammation of the eye. Take, for instance, episcleritis and inflammations of other parts of the eye, without any other manifestations of rheumatism at the time, and many will afterward develop joint complications confirming the diagnosis.

DR. J. B. MARVIN: How do you account for endocarditis following pneumonia? How do you explain cases of ulcerative endocarditis? How do you explain cases of endocarditis following measles and scarlet fever? I think Thomas or Wunderlich puts measles next to rheumatism in frequency as the cause of

endocardial inflammation. Certainly the tendency among German authors is to ascribe endocarditis more frequently to bacterial infection than rheumatic influences.

DR. C. W. KELLY: In reporting the cases in question I did not take into consideration the cause. I am satisfied from observation that both endo- and pericardial troubles are often met with aside from rheumatic diathesis. For instance, in Bright's disease you often meet with pericardial trouble which is frequently the cause of death. You frequently meet with pericardial trouble in the course of typhoid fever, and in these cases it is usually fatal. An especially interesting feature in the cases referred to is that this effusion or lymph within the pericardium seemed to control the heart's action, or to change its rhythm. It was to call attention to this fact that I reported the cases.

DR. WM. BAILEY: It seems to me that a pulse of forty to seventy per minute is a very unusual thing in pericarditis.

DR. C. W. KELLY: It depends altogether upon the patient. If the patient is kept quiet the pulse will be slow, but if allowed to worry or change position the pulse becomes very rapid.

LEFT LARYNGEAL PARALYSIS.

DR. J. M. RAY: This specimen was removed, post-mortem, from a negro aged forty-eight years. I saw him first in March; he came to my office suffering from partial loss of voice. Upon examination of his throat at that time, I found a left laryngeal paralysis, his vocal cord being in what we call the cadaveric position,—half way between abduction and adduction. I saw him once or twice and then he passed from under my observation until about the first of October, when he came to me one morning suffering very much from dyspnoea. I sent him to the city hospital and asked Dr. Rodman to take charge of him. Afterward he was presented to the class by Dr. Yandell. On examination of the throat at that time it was found that the left laryngeal paralysis was complete, and the right vocal cord seemed partially paralyzed. We kept him quiet in the city hospital for a few days with instructions that he be carefully watched whenever he had one of the spasms of dyspnoea. He grew better

of this dyspnoea. Dr. Rodman examined him physically and made diagnosis of aneurism of the arch of the aorta although the symptoms were not very decided. In a day or two he was taken with a violent attack of dyspnoea and died. By post-mortem examination we found a large aneurism of the arch of the aorta. Shortly before the patient died the *interne* performed a laryngotomy but it afforded no relief. I assume that the dyspnoea must have been due to the aneurism pressing upon the pneumogastric nerve on that side. How to account for the inability to abduct the cord on the opposite side, I cannot tell.

This case is particularly interesting to me as I have a similar case under treatment now; a man thirty-nine years of age consulted me in April last, and on examination of his throat I found slight interference with the motion of his left vocal cord; he was very hoarse and had acute local symptoms, œdema, etc. Under local applications they all disappeared, and after thoroughly examining him I made up my mind that he had left vocal cord paralysis. I treated him for a while with little or on improvement in the symptoms. Then he went to New York and consulted several specialists there who told him he had paralysis of the left vocal cord, due to aneurism of the arch of the aorta. Then he came back and under large doses of iodide of potassium his voice has improved, but the left vocal cord is still paralyzed. The right cord has taken on the duty of the disabled cord and now he is able to talk in an ordinary tone without any trouble at all. The man has gained in flesh, is perfectly hale and hearty and attends to his business as wholesale buyer for a large drygoods house. To all appearances he is in perfect health.

DISCUSSION.

DR. WM. CHEATHAM: Dr. Ray's case is certainly a very interesting one. By recent investigations of the recurrent laryngeal nerve, all the symptoms can be easily explained. I have just had a similar case in the person of a white man aged about sixty. He died of rupture of the aneurism. This case has a specific history. A post-mortem was held, but the specimen was lost.

DR. W. L. RODMAN: There is very little to add to what Dr. Ray has said. The man was referred to the Surgical

Ward and after a very careful examination, I thought I detected an aneurism of the arch of the aorta, and the autopsy has proven that my diagnosis was correct.

DR. J. M. RAY: I have seen four cases of laryngeal paralysis since the first of January—in addition to the two here reported, I have seen two others. One is a man seventy-six years of age, who has complete left laryngeal paralysis; another a young lady who has complete paralysis of the left vocal cord. No evidence of aneurism can be found in either of these two cases. I notice that Bosworth reports having seen only fifteen cases of unilateral paralysis. Out of the fifteen cases the trouble was on the left side in eleven and on the right in four. Of the eleven on the left side, only four were due to aneurism and he makes the statement that aneurism is not as often the cause of recurrent paralysis as we might at first be led to believe.

GUNSHOT WOUND NEAR BLADDER.

DR. A. M. CARTLEDGE; I would like to ask Dr. Vance to give us a short resume of a case he reported to this society seven years ago, then I will make a continued report of it. I refer to the boy who was shot in the region of the bladder.

DR. A. M. VANCE: Seven or eight years ago I was called, in an emergency, by Dr. Hays to see a patient who had been shot in the belly. I found a boy about nine years of age, in shock, and with about this history; he had a toy pistol and had bought some Flobert cartridges without balls in them; in endeavoring to load this pistol the bullet that he had put in first would not allow the cartridge to go in, therefore he took a railroad spike to hammer it in; the cartridge was exploded the ball entering his abdomen about two and one-half inches below the navel. Dr. Hays, who was the family physician, was called about half an hour after the accident. The boy was treated for shock, the only symptom or evidence of his having been shot was hemorrhage from the urethra, which was not very excessive. I saw him again in the afternoon. He had reacted fairly well and recovered without any further manifestations. I told the family at that time that I thought the bullet had entered the bladder and believed, in years to come, an opera-

tion would have to be performed for its removal, as a stone would probably form around it.

DR. A. M. CARTLEDGE: Some two months ago I saw this patient with a physician of this city, and substantially the same history was given me as detailed by Dr. Vance. From the subsequent history we all believed that it was a case of bullet wound of the abdominal cavity that had gotten well without a laparotomy. The question was discussed for a long time as to the propriety of doing a laparotomy without any symptoms of a general character indicating the operation. When I saw the patient he was suffering from an abscess (which had been opened by his physician) two inches below the umbilicus and a little to the left of the median line. The abscess opened was still discharging. On account of some trouble in his family the operation was postponed, and the sinus closed and they thought he was about well. Two weeks ago the abscess again refilled in the same region and his physician again opened it a few days ago. I then told them to send him to the infirmary and I would see if we could follow up the original sinus and locate and remove the offending body. We introduced a probe which could be pushed backward at least five inches, I am quite sure it went behind the pubic bone to the left side of the bladder. Then I determined to follow it up in this direction; it was dilated apparently to the bottom, but I could not feel any foreign body with the dilator. I then introduced a soft catheter with a curette, probably about six inches in this direction, but it being of soft material could not detect any foreign body. I again introduced the dilator following up the old sinus and finally detected the bullet, but the question was how to remove it, through the very small sinus. After some little difficulty this small bullet was removed from the left side of the bladder-neck. The sinus was packed from the bottom with gauze. I think the bullet could probably have been removed from an incision through the perineum, if it could have been located. He has made an uninterrupted recovery.

DISCUSSION.

DR. W. O. ROBERTS: Was the hæmorrhage from the bladder during micturition?

DR. A. M. VANCE: Yes. There was only one hæmorrhage and that was during micturition. The boy was relieved of all his symptoms very quickly; was kept in bed for about ten days. I saw him three times only. He was then about nine years of age.

CASES OF SYPHILIS.

DR. E. R. PALMER: I have recently seen two cases of chancre in the female, on the right labium minus, occurring as the initial lesion. I suspected syphilis in both cases, but discovered it by being led through other reasons to make an examination. In one case the chancre has been followed by secondary eruption, which is now fading; the other is in bed to-night with syphilitic fever.

Another case is a man who developed chancre eight weeks after copulation. This is the second case which has come under my observation where infection has come from the same female, the patients each supposing they had contracted gonorrhœa.

The fourth case came to my office four days ago with a small but plainly defined chancre to the left of the frænum. The second or third visit he made he called my attention to a fever blister (as he called it) upon his lip, which I found upon examination to be an immense chancre. It was a case of double infection at two distinct points, contracted from the same female and at the same time; infecting his lip from kissing and the penis from coitus.

STUDY AND PRACTICE.

While common sense is an absolute necessity for any profession or vocation, I know of no one where it is more necessary or important than in the study and practice of medicine. If I were asked to define the term common sense, it might be difficult; but it will be sufficient for our purpose, at this time, to say it consists in applying rational, simple rules of construction to the various theories of medical science, adopting and practicing what can be measured by such rules, and rejecting those that are at plain variance and antagonism with them.—*Ex.*

Correspondence.

"THE CONSERVATIVE."

Editor of MEDICAL AND SURGICAL REPORTER:—"Conservative," according to Webster, is, "one who, or that which, preserves from ruin, injury, innovation or radical changes; a preserver, a conservator." "The Conservative," medically speaking, according to a goodly number of writers in these days of "brilliant" exploits, is a back number, a "chump," a doctor or professor whose platitudes are "fatigueing in the extreme."

If there is one quality more desirable than another, in the profession, it is honesty. Honesty of opinion, honesty in criticism, honesty in treatment, medical or surgical. In this light let us look at the "Conservative." He is not necessarily either a fool, or an old fogey; it does not follow that he takes no journals, nor visits clinics, or "Polyclinics." He is just as likely to possess a Sims or a Goodell, as a Ferguson speculum—and more so. You generally find him as the man who has read both sides of the question. He it is, who, when visiting a clinic, takes it all in and thinks, while the other fellow is blowing about the new operation, and getting only a superficial view of the case. "The Conservative," is the man who has not only seen many old theories die out, old treatments set aside; but new theories wither; new treatment fizzle and new instruments condemned that were ushered into the medical world, in a blaze of light and glory. "The Conservative" is the fellow who wants to know before he acts; who thinks before he speaks. He it is, who has learned how much there is yet to learn, and how deceptive are flashes on the horizon. He it is who wants to know if it is the headlight of a locomotive or the moon that is looming up ahead; a sun or a dog sun that is claiming attraction as a new light. It is not the "Conservative" who never makes a "safe hit." He strikes when he gets ready and is sure to make "first base;" he watches for the safe time to make each succeeding base. He may keep back the impatient fellow "at the bat," but it won't hurt the batter to have time to think a little. It is your "Radical" that generally gets "out on first," seldom reaches "second," and rarely, if ever, "third." Once in a while a fellow who has looked over the whole field and studied

the situation, knows his time has come, strikes and makes a "home run;" but he is one of the very few, and his success was due to "Conservative" thinking, not to "Radical" rush. It is not your "Conservative" who writes:—

SOONERVILLE, April 1st, 1892.

MESSRS SMITH & DUBS.

Gentlemen: It is most gratifying to be able to report that since I added your "Smith's silent perambulating pills" to my armamentarium, I have had three cases of Leucæmia in which they were exhibited. Recovery was rapid in cases one and two. But in case three, owing most probably to inefficient and partly ineffectual absorption, resolution was prolonged about ten days. A difference of 50 per cent. compared with cases one and two. The profession owe you a deep debt of gratitude. I shall continue to use your S. S. P. P's in all cases. Please send me another dollar's worth.

Very fraternally yours,

JOB LOTS, M. D.;

Gilhooly Col., '89.

It is the "Conservative" however who, after reading similar certificates, piously exclaims, "The good Lord help that fellow's patients, when they do get sick!" It is the "Conservative," who knows that patient has a liver, spleen, kidneys, stomach, and "other things," and finds out "how they are," and "how they have been." It is your Radical, who says, "Let me see your tongue, please. Ah! I thought so, I will have to make a vaginal examination."

Your conservative physician says, "we will try injections." It is the radical who exclaims, "give him mercury, it will go through him, or bust a gut." It is your conservative surgeon who says, "I can save that leg." It is the radical that utters, "whack it off, I'll do a semi-circular with a triangle trim, flaps too ancient." It is your conservative gynecologist who says, "this patient is a woman, I will try and keep her a woman, with all her womanly functions intact." It is your radical who says "I'll extirpate these ovaries, and shorten that round ligament. She will never be a mother, and that probably suits her, and positively suits me, for here is, name, fame, and three hundred dollars."

"He pleasantly smiles when the deed, it is done,
Saying, 'Pinko Chanky, isn't it fun.'
(Apologies to the author of "Witless Whanks whoo.")

It is the conservative gynecologist who knows, that it was the mental effect of an operation for a supposed ovarian disease that cured, at least for a time, the real neurosis. It is your conservative, who knows, that healthy ovaries, have been removed to cover up faulty diagnosis; and who realizes, that, if what is now said about the necessity or advisability of abdominal surgery were all true, a large per cent. of his female patients would have joined the great majority long ago. The conservative knows a good thing when he sees it, or it comes to him mentally. He knows a "craze," and has it sized up while the radical is trumpeting his short lived triumph. He it is, who thinks of the awful *unwritten* history; while he is ready to sanction, or to operate to the extent of his ability, when operation is justifiable. It is he, who knows that not even a respectable minority of practitioners have it in them to be experts in gynecology, or special surgery. It is all very well to poke fun at the poor tyro with his "Ferguson" and his tampon; his sound and his battery; but it is a burning shame on the medical profession to advocate, in the same breath, the ruthless and often unnecessary, destruction of the womanly functions. Dr. G. G. Shoemaker, a Penna. University man, and one of the best fellows, in the world, remarks to me, in this connection, this—"My own opinion is, that in a majority of cases, it is the *other* sex that should be attacked. That this world would be better, and freer from disease, physical and mental, if a little judicious *castration* were performed. This would not interfere with the peeling of bark, drinking whiskey, pumping beer, parting his hair in the middle, or wearing an "oy gloss y' knaw," but it would cut down the production of criminals, imbeciles and lascivious libertines."

That idea is a good one. Now in the not distant future, when the conservative has caught on to the good, and knocked out the bad, in present pelvic surgery, the radical will have to take a new departure.

The doctor's idea, will give him a starting point. Let the radical castrate for a—well, let us say, a gonococcus; amputate in part or wholly, the penis, for ulcer or stricture; and in the mean time, fire hot shot, into the old bougie, syringe, caustic, mercury and iodides. The more you think of it, the more one sees that this doctor is right. The results normally and

physically would outstrip present methods, and this world would be better. But, alas! the male would not put up with it, or *for it*. He prefers, as ever, to let the woman bear the penalty.

However, the doctor's idea is too radical for the purposes of this paper, and we go back to the "Conservative."

I had a patient come to me, whom three experts, (and I say experts as those "away up" in their speciality), had declared, had diseased ovaries, and "they must come out." I did not think so, and after a careful examination wrote the whole history of the case, and symptoms to Prof. Goodell. Result, I was right and experts wrong. Rest, Bland's pills, corrosive sublimate, and the despised "Smith Hodge" pessary did the work. Another patient, who was certain she had all the ills the female pelvis is heir to; who had been treated again and again, was cured by simply staying in bed. I gave her an essay of Dr. Goodell's to read, which so accurately described her case that its mental effect largely aided the cure. These are only trifles by the way-side, but they are trifles that are repeatedly magnified into conditions for operation.

Your "Conservative" knows that he must be prepared to do a Cæsarean section; but he also knows that if he is going to make a business of abdominal surgery he must have the conditions right. First, right himself; second, surroundings right—patient under constant surveillance by trained nurses, with skilled fingers and perfect cleanliness. If he can't have these, and all these, he won't operate (unless in an emergency) and he is foolish if he does. Better, far better for him and patient, to let her go where all these things can be had. I almost fancy, I hear some good-natured Radical softly singing at this point:

"Oh! Mother, may I go out to swim?"

"Yes! my charming daughter,

"Hang your clothes on a hickory limb,

"But, don't go near the water."

That is all right for him but, here's to the "Conservative" brother—I am not sure I belong to his tribe. I am afraid I am somewhat mixed. But, here's to him! To him, I lift my hat, and I drink his health in spring water. He is a royal good fellow; the great balance wheel that keeps us all in check, and prevents the Radical from annihilating the whole race in order to preserve a specimen.

S. S. TOWLER, M. D.

Marienville, Pa.

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THE MEDICAL AND SURGICAL REPORTER.

SATURDAY, DECEMBER, 24TH, 1892.

MEDICAL LEGISLATION IN PENNSYLVANIA.

ABSTRACT OF BILL UNANIMOUSLY ADOPTED FOR
PRESENTATION TO THE LEGISLATURE BY THE
MEDICAL SOCIETY OF THE STATE OF
PENNSYLVANIA.

1. The Board shall consist of nine members, graduates of some legal medical school, "no two of whom shall be residents of the same County, and none of whom shall be a member of the faculty or staff of any medical school or university."

2. The members shall be appointed by the Governor by and with the advice and consent of the Senate.

3. Only physicians commencing practice in Pennsylvania after July 1, 1893 "shall be examined in anatomy, physiology, chemistry, pathology, hygiene, toxicology, differential diagnosis, surgery, and obstetrics; and each applicant, upon receiving from the secretary of the board an order for an examination, shall draw by lot a confidential number, which he or she shall place upon his or her examination paper, so that when said papers are passed upon by the examiners the latter shall not know by what applicant

said papers have been prepared, and upon each day of examination all candidates shall be given the same set of questions."

4. The examination papers and marks shall be preserved and shall be open to public inspection in case of dispute. "No one shall be excluded or rejected on account of adherence to any special system or school of practice."

5. "Each applicant who shall have passed a satisfactory examination shall receive from the said board under seal a license to practice medicine and surgery in the Commonwealth of Pennsylvania.

6. "Nothing in this act shall be construed to prohibit service in cases of emergency or the domestic administration of family remedies."

7. The applicant shall pay an examination fee of ten dollars and "in case of failure at any examination shall have the privilege of subsequent examinations without the payment of an additional fee."

The Committee of the State Medical Society has just issued a pamphlet calling the attention of the profession to the necessity of urging the Legislature to pass the bill prepared for the creation of a State Board of Medical Examiners. This pamphlet gives the views of physicians from all parts of the State, and shows that the desire for some legislation to protect the public from ignorant practitioners is a general one. The legality of such legislation is proved by extracts from decisions of the Supreme Courts of the various States and also from the Supreme Court of the United States. A very forcible quotation is given from the decision of Justice Field of the United States Supreme Court. He says:

"No one has a right to practice medicine without having the necessary qualifications of learning and skill; and the statute only requires that whoever assumes, by offering to the community his services as a physician, that he possesses such learning and skill, shall present evidence of it by a certificate or license from a body designated by the State as competent to judge of his qualifications."—(U. S. Supreme Court, 129 U. S. 114).

There are already twenty-four States and Territories which require physicians beginning practice within their limits to exhibit their proficiency and knowledge before medical authority established by State law.

The fact that separation of the licensing power from the teaching power is earn-

estly advocated by President Eliot, of Harvard University, is strongly brought forth. Such an opinion coming from one who is interested in education, and yet not a physician, carries great weight.

The pamphlet gives the Faculty Resolutions of the Jefferson College, the University of Pennsylvania, the Woman's Medical College and the Polyclinic endorsing the bill. This shows that these progressive and broad-minded medical schools are fully aware of the risks of allowing teachers of a faculty to confer licenses to practice.

The members of the State Society must certainly be gratified to see these well-known schools take such high ground in advocating reform which has been so long needed.

Dr. Millard, of Minneapolis, has truly said that the enemies of a State Board of Medical Examiners principally include the representatives of those colleges governed by *commercial* interests, whereas, the friends of medical legislation include the mass of the profession and those who represent the better colleges of the country. The general profession well know that the opposition to the Medical Examiners Bill usually comes from the "two year's" schools and from those who are afraid that their graduates cannot stand a reasonably searching State examination.

Copies of this document can be obtained from the members of the Legislative Committee of the Medical Society of the State of Pennsylvania, the Chairman of which is Dr. H. G. McCormick, of Williamsport.

The REPORTER hopes that every honorable effort will be made to support the bill and to assist in its enactment as a law.

ANÆSTHETIC SALVE FOR HEMORRHOIDS.

The following is given in *Med. Chir. Centralbl.*

R	Cocaine	grs. iij.
	Morphia	grs. ivss.
	Atropine sulphate	grs. iij.
	Tannin	grs. iijss.
	Vaseline	3v.—M.

Apply after each evacuation of the bowels.

Translations.*

By MARIE B. WERNER, M. D.

Operative Treatment of Epilepsie, by Dr. H. Kümmel, of Hamburg (*Deutsch Med. Wochens.*, 23, 1892). The author reports seven cases of genuine epilepsy, on whom he attempted various operative procedures.

In the first two patients he followed W. Alexander's method, and ligated the vertebral artery, but neither the unilateral, or later the ligation of the opposite artery, resulted in any but a passing improvement.

Alexander's theory being, that by ligation of the vertebral artery, some of the nerve fibres of the sympathetic passing from the ganglio cervicale superius, are included, which severs their connection with the superficial portions of the brain.

W. Alexander even extirpated the ganglion in question with the hopes of producing a cure. The author also extirpated it in a woman æt, 46, with but transient improvement.

Trephining was practiced by Kümmel in five cases of genuine epilepsy, in which there was no history of trauma, nor was it possible to localize definitely the seat of the motor center affected by the history of the attack, a persistent painful spot, however, always showing itself after the attack; served as a guide to the operator, and the desirable results attained after trephining, served as an encouragement to the author. There were no appreciable anatomical changes found.

The most favorable results however gained, are in those cases of so-called Jacksonian Epilepsy produced by trauma. Kümmel operated in three such cases, excising portions of abnormal dura mater with complete cure in two cases.

The author further reports a case of Iodicy in a three year old boy who had a deep depression below the lamdoid suture—resection of the depressed portion resulted in recovery and marked mental improvement.

Dr. H. König, of Hermanstadt, (*Munch Med. Woch.*, 1892) presents a very interesting account of the recovery of six corpses which were forcibly thrown out of the Echo-schaft, with large quantities of

* Translated for MEDICAL AND SURGICAL REPORTER.

water, during a severe storm July 3, 1890. They were found floating on the top of the Iod-Soolbad-Salzburg.

Careful examination proved them to have been victims from the battle near Salzburg, February 4, 1849. They were all excessively heavy; the tissues were thoroughly macerated with salt water; quantities of salt crystals were found internally; rigor mortis was present to a slight degree; no decomposition; the odor compared to pickled meat; and they appeared like bodies kept a long time in alcohol.

The skin was ashy gray, hard, smooth and devoid of hair; the mucous membrane pale. The nails were incrustated with a thin, yellowish substance.

The bodies being frozen when thrown down the shaft, presented quite plainly the injuries received, *i. e.*, fracture of the skull, punctured and shot wounds and injuries from blows.

The integument on being cut, looked much like bacon, the internal organs were apparently fresh—for instance, the liver substance on being cut, was dark brown in color, and its structure well preserved. This state of preservation was found in all organs except the brain, which had changed into a reddish-gray fluid.

Kümmel calls attention, 1st. To the wonderful conserving properties of the water in the Echo shaft.

2d. That the fluid entered into the deepest structure, crystals having been found in the spongy portions of the bone.

3d. That the number of years (41) which elapsed since the bodies had been exposed to the action of this fluid, gave ample proof of its penetrating qualities, since crystals were found in organs entirely shut off from direct contact.

For these reasons Kümmel thinks this water can easily take the place of the more expensive alcohol for museum specimens. A chemical analysis has not yet been made.

Buglioni—Fracture of the spinous process of the seventh cervical vertebra—(*Raccoglitori Med.*, 1892, June 20). Patient, a boy between fourteen and fifteen years, while playing was thrown face downward, another boy falling upon him, his elbow resting upon his neck; the little patient at once experienced a sharp pain. On being examined a few hours later Bug-

lioni found a complete separation of the spinous process from the seventh cervical vertebra. Absolute rest and proper bandages resulted in complete union in twenty days. An isolated uncomplicated fracture of this kind is certainly of rare occurrence.

Holländer, in his studies on the use of Pental as an anæsthetic, (*Deutsch. Med. Wochen* 1892, page, 857) after having used it for some time, presents the following conclusions: 1. Pental is in all cases an active anæsthetic; it differs in this from Bromide of Ethyl, which has failed in some cases. 2. Anæsthesia sets in more slowly than in Bromide of Ethyl but lasts longer and the patients recover from its influence more slowly.

3. Holländer has never noticed nausea or vomiting follow its use, and but rarely observed any symptoms of excitation.

4. Neither respiration nor the heart is influenced during narcosis—exceptionally there has been a slowing of the pulse in the anæmic or a slight increase in the excitable.

5. For some patients 2-3 c. c. are sufficient to induce narcosis; in all cases as a rule 10 c. c. are sufficient.

6. The excitable or markedly anæmic patients with weak heart's action, or old bronchial catarrh, do not stand Pental well.

7. The Junker apparatus is best adapted for its administration; the fumes are kept from the eyes, a smaller quantity is used, the unpleasant odor is not so easily noticed and the quantity can be regulated.

8. Narcosis is complete in one to three minutes.

Schmidt—Acute primary hæmorrhagic encephalitis (*Deutsch. Med. Woch.* 1892). A girl of nineteen, having enjoyed previous good health, having been subjected to some undue strain, began to suffer from intense general headache and vomiting; this was soon followed by apathy, and short epileptiform attacks, the latter increasing in frequency. There was occasional conjugated deviation of the eyes to the left, slow respiration, coma and death. Section, revealed hæmorrhagic encephalitis, red softening of both optic thalamus and corpora striatum, extending farther to the left; blood in both lateral ventricles, most in the left.

Abstracts.

MEDICAL EXAMINING BOARD OF VIRGINIA.

We append a few of the question that were presented to the candidates at the examination held at Alleghany Springs, Sept. 14 and 15, 1892.

As the questions in the different sections were very fair and cover considerable ground, we give a few, for the study of those interested in efforts to advance medical education.

SECTION ON CHEMISTRY.

Q. 4. "What are alkaloids? mention three of the more important, and give the physical and chemical properties of each."

Q. 5. "What are the properties of ozone? In what respects does it differ from oxygen?"

SECTION ON ANATOMY.

Q. 1. "Describe the anterior cerebral fossæ."

Q. 2. "Name and describe the ligaments of the knee-joint."

SECTION ON PHYSIOLOGY.

Q. 1. "Give the physiology of the lymphatic system, so as to include the following items: (a) Anatomical structure and arrangements of lymphatic vessels, from their origin in the tissues, to their place of communication with certain veins. (b) Special office of lymphatic glands."

Q. 6. "What effects follow section of the facial nerve after exit from the stylo-mastoid foramen?"

SECTION ON MATERIA-MEDICA.

Q. 5. "Name the most efficient antispasmodics; Give doses of each."

Q. 6. "What are "excito-motors" and what are depresso-motors? Give examples of each group with doses."

SECTION ON OBSTETRICS.

Q. 1. "To what diseases are pregnant women most liable? Give pathology of each."

Q. 4. "What measures are absolutely necessary to prevent septic infection during the process of parturition?"

Q. 5. "Give diagnosis of pelvic peritonitis, its treatment and possible sequelæ."

SECTION ON PRACTICE OF MEDICINE.

Q. 2. "Give the symptoms and physical signs of aortic insufficiency and diagnose it from mitral obstruction."

Q. 5. "Differentiate broncho-pneumonia from lobar pneumonia."

SECTION ON SURGERY.

Q. 1. "Diagnosis and treatment of penetrating wounds of abdomen, with visceral lesions."

Q. 3. "Differential diagnosis in detail of chancre and chancroid."

Q. 5. "Symptoms of arthritis and synovitis."

Q. 6. "Differential diagnosis of tetanus, hydrophobia, and spinal meningitis."

INTUBATION OF THE LARYNX.

Dr. James B. Ball, of London, gives an interesting report of twenty-two cases of intubation of the larynx in (*The Lancet*, Nov. 26, 1892). Sixteen occurred under the care of some of his colleagues at the West London Hospital, the remaining six belonged to his private practice. All were children ranging in age from thirteen months to eight years. Of the twenty-two ten recovered. Intubation was performed in every case for symptoms of acute laryngeal stenosis which threatened the life of the child, and as the alternative of tracheotomy. In two cases the laryngeal trouble arose from traumatic causes,—in one from swallowing very hot tea, in the other from swallowing carbolic acid. The rest were cases of laryngitis, simple or membranous (diphtheritic); it was not always possible to distinguish which.

In five cases the disease was secondary to measles, four of these died. In seven cases tracheotomy was performed after intubation had been tried, principally because the tube seemed to be clogged with membrane or secretions. All of these died.

In the cases which recovered the tube was left in the larynx for periods varying from three to thirteen days, the average period for the ten cases being eight days. The thread was allowed to remain *in situ* in four cases, and in one of these it is noted that the child dragged the tube out by its means. In the rest of these cases the thread was removed immediately after

the introduction of the tube. The author thinks it the best plan to remove the thread at once.

In two cases an ulcer was found *post-mortem* on the anterior wall of the trachea, at a point corresponding to the position of the lower end of the tube. It is only right to mention that the tubes used in these cases were not constructed in accordance with O'Dwyer's later patterns.

The author continues to say: "I have no intention here to make any remarks on the value of intubation or on the relative merits of intubation and tracheotomy.

I will merely say that in two of my own cases both of which recovered, tracheotomy had been previously recommended as the only chance of saving the child's life, and had been declined by the parents owing to the slender hope which was offered even if the operation were performed.

In both these cases they gladly consented to the mild and bloodless operation of intubation, although I only held out an equally slender hope of recovery. In this way I feel sure that some lives may be saved by intubation which would otherwise not be saved, and, moreover, the operation is not so likely to be deferred until the child is *in extremis* as tracheotomy often is."

"INFANTILE RESPIRATORY SPASM."

In a paper recently read before the Edinburgh Medico-Chirurgical Society, Dr. Thompson gave a short account of five cases that had come under his observation in which this curious and interesting condition had existed. It is also known as congenital laryngeal stridor, or infantile laryngeal spasm, and Dr. Gee has described a similar, although somewhat different, condition under the term "respiratory croaking." Of Dr. Thompson's five cases, three were boys and two were girls, whereas in all previously recorded instances where the sex is mentioned it seems to have been confined to girls, and the condition is often said to occur only in female children. As regards family history and general health, there is nothing of very great significance, except that in four of the cases more or less indigestion was present. In none of the patients was rickets apparent when the children were first seen, but it appeared

later in those longest observed. There was no sign of congenital syphilis in any of the cases, and intellectual development seemed perfectly good. The onset of the stridor was noticed in three instances immediately after birth, in one infant it was not observed until a week, and in the other a fortnight later. As regards the course of the malady, Dr. Thompson says that in very severe cases the stridor goes on increasing in loudness during the first two or three months and then tends to subside spontaneously, and as improvement goes on the intervals become longer and the sound less loud, that accompanying inspiration, the crowing sound, disappearing first, while the croaking may still be present at times. After the stridor has ceased to be heard under ordinary conditions it may appear if the child is specially excited or angry; when the stridor is present inspiration begins with a croaking noise and ends in a high-pitched crow. When the breathing is quiet the latter does not occur. Expiration is accompanied by a short croak when the stridor is loud, but at other times it is noiseless. As regards other symptoms, the indrawing of the chest-wall and the episternal notch were well marked in four of the cases, but the *alæ nasi* did not move with the respiration, and there was a striking absence of distress or cyanosis. Variations in the intensity of the sounds were not uncommon and there were occasional intermissions, even when the condition was most constant and severe. The sounds were notably intensified by mental perturbation, more so, apparently, when the child was excited and apprehensive than when actually crying. Sleep seems to have no constant effect on the condition, and it does not cease when the tongue is depressed, nor even when the nostrils are closed; and when the child is taking the breast there is still sufficient air entering the nostrils to cause loud stridor. The effect of the ailment on the general health is not great, and the most effective treatment apparently is by regulation of the diet and other general precautions. Dr. Thompson regards the condition as due to spasmodic muscular contraction, the cause of this being some central disturbance of function, and he considers it closely analogous in nature and etiology to ordinary speech stammering, both being the result of defect in the proper co-ordinating mechanism.—*Lancet*.

**COLLAPSE AFTER OVARIOTOMY—
TRANSFUSION—RECOVERY.**

DR. LEONARD REMFRY.

Married woman, aged twenty-eight, admitted to Great Northern Hospital, October 12, 1892. Examination showed a large, rounded, fluctuating tumor of the abdomen, rising to within three inches of the ensiform cartilage; more prominent on the right side. Dr. Remfry operated. There were no adhesions. The tumor, which contained a dark grumous fluid, was for the most unilocular, containing but a few secondary cysts; the pedicle was broad and contained some unusually prominent vessels; these were first all tied separately and then the rest of the pedicle secured in the usual way, including the first ligature. The stump was returned perfectly dry. The patient took the chloroform well and the operation did not occupy more than forty minutes.

Five hours after the operation, the patient began to vomit and retch repeatedly and became restless. Temperature subnormal, pulse 120; restlessness and pallor increased and she complained continually of pain in the left iliac fossa; one and a-half hours later, the pulse 140, could scarcely be detected at the wrist. Ether and brandy were given hypodermically and champagne by mouth with no improvement; examination per vaginam proved Douglass' pouch apparently empty. The extreme collapse contraindicated surgical interference. Transfusion was resorted to as a last chance, salt and water (one and a-half drachms to the pint) at a temperature of 110° injected into the right median basilic vein. Two and a-half pints were injected with numerous short intervals. After half a pint had been used a distinct improvement was noted, which continued steadily; nutritive enemata were also an important feature of the treatment; the thirst was controlled by occasional sips of hot water. Eleven days after the operation she was practically well.

Dr. Remfry closes the report with the following remarks: "The case is a highly interesting one—first, because of the extreme collapse so gradually developed, and, secondly, because of the equally gradually-developed recovery and the efficacy of transfusion. What was the cause of the collapse? It is impossible to speak with certainty. Was it hemorrhage or was it one

of those obscure disturbances of sympathetic origin? Against the theory of hemorrhage it is impossible to bring forward any one decisive argument. The following details should not, however, be lost sight of, as collectively they are important. (1) the special care with which the pedicle was tied and its bloodless appearance before the abdomen was finally closed; (2) the steady improvement under transfusion, without the occurrence of any further, even temporary, collapse; (3) the absence of the least resistance in Douglass' pouch; (4) the almost normal respiration throughout. I may add that beyond passing a sponge into the pelvis and feeling the left ovary with two fingers there was no manipulation inside the abdomen."

—*Lancet*, Nov. 26, '92.

**CHRONIC DYSPEPTIC STATES
TREATED BY MENTHOL
· SPRAY THROUGH THE
STOMACH-TUBE.**

In the *International Medical Magazine*, November, Dr. A. L. Benedict reports several cases and says:

The technique of the administration of menthol through the stomach-tube is simple. The patient should be directed to take no food within at least four hours of the time of appointment and the last meal should be a light one. Lavage is practised in the ordinary way, using plain water or a weak alkaline solution of about the body temperature, and repeating the washing until the fluid returns free from shreds of mucus. The water is removed from the stomach by siphonage as completely as possible, stripping and shaking the tube to remove the water remaining in it. The contact of the tube with the walls of the stomach is apt to excite retching. Haste should be made, therefore, to distend the organ with the spray from the atomizer. The writer uses a one- to five-per-cent. solution in any of the colorless substitutes for the crude officinal liquid petrolatum. The form of the atomizer is a matter of indifference, as almost any of the cheap nickle-tube perfume atomizers will spray an oily solution. The spray is then directed into the funnel, a piece of cardboard being used to prevent a rebound of the vapor from the sides of the funnel, or the funnel may be removed and the tip of the atomizer introduced into the lumen of

the tube. For a minute or two the vapor from the atomizer will meet with some resistance from the small amount of water remaining in the tube, and on auscultation a bubbling may, at times, be heard in the stomach. The vapor, like the fluid previously used, should have an alternate ingress and egress. By pinching the tube close around the tip of the atomizer the stomach may be fully distended and it should then be allowed to contract upon its gaseous contents, when the vapor and even drops of water will be expelled with considerable force from the mouth of the tube. No better proof of the fact of the entrance of the spray into the stomach can be afforded than the almost invariable statement of the patient that the peppermint can be tasted in the mouth, which it can reach only by regurgitation through the œsophagus outside the stomach-tube or through the blood circulation. After having forced the vapor into the stomach, and having allowed the stomach to contract upon its gaseous contents six or seven times, it is safe to assume that the walls of the organ have become as thoroughly coated as would the pharynx or the nose after the same number of applications, barring the fact that the vapor has to follow a longer course and that the surface to be medicated is of much greater area.

The finely-divided spray of an oily solution of menthol distends the stomach symmetrically with little tendency to gravitate to the greater curvature and without straining the ligamentous and peritoneal attachments of the stomach. The vapor diffuses itself in all directions, touching almost every cell of the mucous membrane with a tiny oil globule holding in solution a small amount of menthol. In the aggregate, the clean surface of the stomach is coated with a medicated film of inert mineral oil. This film forms an antiseptic dressing for the mucous membrane, has little if any irritant action aside from the excitation of the menthol, and is, for the most part, brushed off by the first food which enters the stomach. The action of the menthol must be almost entirely local, for the oily solution, though strong enough to act on the mucous membrane, is not used in sufficient volume to make the constitutional action of menthol noticeable.

The value of the menthol spray has been

so thoroughly demonstrated in the treatment of more accessible mucous membranes that it seems pardonable to report this new use of it without waiting for a longer series of cases or a greater lapse of time to speak more emphatically in favor of its local action in the stomach. The nine cases reported (and several others not mentioned in this paper) seem to show that the use of the menthol spray in cases of atony or catarrh of the stomach is followed by at least temporary benefit.

The use of other remedies in spray form is suggested.

PERCHLORIDE OF IRON IN PARALYSIS OF THE BLADDER.

Dr. G. S. Roads, in the *Massachusetts Medical Journal* (Nov.), reports the case of a man, æt. seventy-four, who had been subjected to attacks of retention of urine, which were formerly relieved by warm baths, etc. He was suddenly called, and found the patient suffering greatly from retention of urine, which was drawn off. An enlarged prostate was found.

The catheter was passed for several days until the urethra becoming very irritable and the patient rapidly getting into a typhoid condition.

There was not the slightest attempt at contraction of bladder.

He then injected into the bladder six ounces of a weak solution of tincture of iron, which was allowed to remain about half a minute. A slight contraction immediately followed, and small quantities of urine were passed during the day, voluntarily.

Improvement was then rapid; and he has had no trouble since (one year). There could be no doubt that the injection effected the cure in this case as no other medicine was given save a simple aperient.

CHRONIC DIARRHŒA WITH INTENSIVE FERMENTATION.

R	Salol	3ij.
	Castor-oil	3xv.
	Syrup of rhubarb	3xxx.
	Gum of acacia enough to make emulsion.	

Distilled water

M. Sig.: One tablespoonful every hour until the bowels move.

—*Le Prog. Méd.*

Periscope.

THERAPEUTICS.

THE TREATMENT OF CHOLERA IN THE ALTONA HOSPITAL.

Dr. Du Mesnil has had under his observation about five hundred cases during the last epidemic. To destroy the bacteria *in situ* he administers calomel in seven-grain doses twice in the course of two hours, following with grain doses every second hour, believing this to be of more value than salol, creolin, or other cresol preparations. Further antisepsis he obtains with Cantani's tannin injection (10:2000). To meet the indication presented by the abstraction of water from the tissues and thickening of the blood and the resultant symptoms, he employs the sodium chloride infusion injected into the veins. He stimulates the heart, when it is required, with camphor, makes use of baths, 90° to 96° F., and relieves vomiting and muscular cramps in legs by morphine. The morality, excluding the cases of diarrhoea when the diagnosis was not established, was fifty-eight per cent.—*Müch. med. Woch.*, 1892.

ARSENIC AS A PROPHYLACTIC.

Dr. C. E. Bryan, in his address as President of the Leicester Medical Society, stated that he had been led by a paragraph in the *Practitioner*, some ten years ago, to the effect that persons taking arsenic were insusceptible to vaccination, to try the drug as a prophylactic in scarlet fever. He believes that an epidemic was checked in the Leicester Workhouse in 1882, and mentioned that a year later, in a family in which one child had severe scarlatina, he put the other two children on arsenic, and they did not take the disease, though they continued to be about the patient until her death three weeks later. In another family a boy, aged seven, had scarlet fever, but the four other children, whose ages ranged from three to eleven, did not contract the disease, and the mother, who aborted during her attendance on the child, did not suffer. He also advanced some evidence suggesting the value of arsenic as a prophylactic against diphtheria and influenza. He gives gr. one-fortieth of arsenious acid in pill, or m ij of liquor arsenicalis, in mixture three times a day for the first week, and afterwards twice a day.—*Br. Med. Jour.*

THE ANATOMICAL CHANGES IN POISONING BY SUBLIMATE.

Dr. Andrea Calantoni presents a very thoroughly scientific and carefully prepared paper, based upon the literature and upon experiments in the laboratory, from which he deduces the following conclusions: The sublimate penetrating into the blood is eliminated by the kidneys (in a large part) and by the intestine, giving rise, in these organs, to changes of a necrotic nature. In the kidneys, a single large dose being followed by death in a few hours, no changes, save small hemorrhages in the inter-cellular tissues, are found. If life is prolonged from five to ten hours there is found cloudy swelling of the protoplasm; if still longer, epithelial necrosis is clearly shown. In some cases of subacute poisoning there is found a deposition of lime, but differing from the calcareous metastasis of Virchow, in that it is a calcification of single elements and not a secretion of lime from acute decalcification of bone or modification of diffusive power of the renal filter. In the intestine the alterations are chiefly found in the large intestine, and consist of hyperæmia, hemorrhage, and necrosis at the summit of the folds, presenting all the characteristics of a diphtheritic process. There is apparently no relation between the severity of the renal and intestinal lesions. The results of necropsy do not furnish a sure, but only a probable anatomical diagnosis.—*Giornale del. Assoc. Napolitana de Med. e Natur.* 1892.

THE USE OF STRYCHNINE AND DIGITALIS IN DIARRHŒA.

Mr. Harold Hendley notices that, in fevers of a remittent character, the complication of persistent diarrhoea occurred frequently, and at periods when the patient was worn out by fever and the digestive powers were rapidly failing, determined to use these drugs to combat certain symptoms. In these cases the temperature ranges from 1° to 1½° above normal, the pulse is soft and yielding, not very rapid, and markedly wanting in tone; the motions, four or five daily, increase in number until nourishment appears to excite an action of the bowels, marked by even a greater tendency to fluidity, the extreme being reached when the motions escaped involuntarily, and is followed by a tendency to cardiac failure, if not collapse, frequently accompanied by a consciousness

of approaching dissolution in the patient. Digitalis was chosen for these cases because of its well-known general action upon the vasomotor system, strychnine for its less-known more direct action upon that portion of the system concerned in the control of the blood supply to the intestines. The mixture employed was tr. digitalis, miv; liq. strychninæ, mij; spts. chloroformi, mv; in water, and repeated at from one to four hourly intervals.—*The Practitioner*.

THE TREATMENT OF CERTAIN REBELLIOUS HEMORRHAGES BY COUNTER-IRRITATION OVER THE SPLENIC OR HEPATIC AREA.

Dr. L. H. Pettit, calling attention to the close relationship which exists between spontaneous hemorrhages and chronic diseases of the liver, regards the logical treatment of this symptom to be the application of counter-irritation over that organ. *En résumé*: in the event of an abundant spontaneous hemorrhage, or if it is repeated, it is necessary to examine with care the condition of the liver, spleen, and kidneys, and if these organs are diseased it is indicated, at least as far as the liver or spleen is concerned, to apply a cutaneous revulsive more or less energetically in these regions—either blisters or the actual cautery. A milk diet is indicated in the case of nephritis. Perhaps it is advisable that we should also employ digitalis in hemorrhages due to cardiac disease. The intensity of the necessary revulsion varies according to circumstances; in some cases vesication for an hour is sufficient, in others energetic and repeated applications are necessary.—*L'Union Médicale*.

VERATRUM VIRIDE IN PNEUMONIA.

Let me recapitulate. Don't bleed unless you want to. You will occasionally lose a patient, perhaps, by not doing so, but never mind. Maybe he would have died anyway. Don't give antimony unless you feel like it, or a calomel cathartic either, but give veratrum, whatever else you do, and don't get worried when your patient's pulse gets down to sixty or thereabouts, but just hold it there and keep the heart from forcing blood into the inflamed lung at such a terrific speed. Some authority, that I can't lay my hand

on just now, says that there is no more reason for controlling the circulation with an inflamed lung than with the inflamed Peyer's glands of typhoid fever. Don't you believe it. The pulmonic circulation is one-half that of the entire body, and anything you can do to lessen the engorgement of lung tissue will diminish the chances of your patient's dying of heart-failure from lack of proper aëration of the blood, and will hasten resolution, vagus or no vagus. But don't give opium.

Finally, permit me to say that with this method you have a positive treatment, so simple and so plain that the wayfaring man, though a diabolical idiot, can understand it, and it means business. And, further, allow me to add that, if you permit your patients to die with uncomplicated pneumonia, somebody is to blame, and an action for malpractice should stick on you quicker than in case of death from lack of the use of antiseptics in midwifery.

Lastly, this is not an idle fancy or a theoretical problem, but a hard and horny-handed fact, proved, not by a few years of hospital training, supplemented by a diaphanous general practice, but by over a third of a century of rough and blistering experience in active practice, where pneumonia was one of the commonest diseases, and I can say with truth, as before intimated, that during all these years I have never lost a single case where the disease was uncomplicated, and very few that were. Furthermore, I never expect to. When gentlemen can formulate a plan productive of better results, it will be time for me to consider it.—*E. B. Ward in American Lancet*.

MEDICINE.

EMPHYEMA.

Herz (*Centralbl. f. klin. Med.*, October 15th, 1892) maintains, in reply to Rudolph (Epitome, May 28th, 1892, par. 468), that, except in some unusual cases, resection of a rib complicates the operation as washing out the pleural cavity does the after-treatment. The delicate pleuritic adhesions by which the re-expansion of the lung is maintained are broken down by the washing out and the recovery delayed. Any masses of lymph find their way out through a sufficiently long incision kept open by two drainage tubes, or

are absorbed without retarding recovery. The washing out is said by Rudolph also to exert a certain influence in producing deeper respiratory movements, and in thus favoring the more rapid re-expansion of the lung, but the same effect can be brought about in other ways. It is also stated that the washing out cannot be omitted in cases of foetid empyema, but Herz points out that a thorough disinfection of the parts is not possible, since the infective process is not limited to the mere surface of the pleura. A case of foetid empyema is then reported in which the patient died of cardiac failure six days after the operation. No rib was resected, and no washing out practised, and yet the empyema cavity has contracted so as to hold not more than 30 c.c. Fine pleuritic adhesions were found all over the rest of the lung. No cause for the foetid character of the empyema could be found. There was dilatation of the heart, and marked fatty degeneration of its substance. This case shows that foetid empyema may be cured by simple incision. It is not by the formation of granulations nor yet of masses of lymph, that recovery is brought about, but by the formation of these adhesions.—*Brit. Med. Jour.*

CONVULSIONS IN CHILDREN.

Safe rule in all cases to see that stomach and alimentary canals are emptied. For this, give a full dose of ipecac, repeating in ten minutes if necessary. If this fails to bring on vomiting, tickle the fauces till successful. Give a copious enema and follow with a half-ounce dose of castor oil. After purging, give chloral till relief is obtained. For a child two years of age, ten grains in a little water can be given per rectum. A child one year of age will stand half the quantity. Morphine may be used if the convulsions are due to uremia. If scarlet fever or measles is coming on do not purge too freely, as it delays eruption. The popular hot bath should be used with caution. If the cause of the convulsions is the advent of an infectious disease it may do good, as it brings the blood to the surface of body and relieves internal congestion. If the convulsions are due to central lesions, when treatment is of no avail the hot bath may possibly be used for the consolation of the patients.—*Ex.*

ON THE TREATMENT OF CROUP.

Pilière read a paper on this subject before the Paris Academy of Medicine. After the year 1880, said the author, he treated with the greatest possible success all the diphtheritic forms of the disease in the following manner:

He washed out the pharynx morning and evening with a cotton brush dipped into a solution of nitrate of silver of 1:30 strength, detaching as much as possible of the false membrane. After each washing he atomized a solution of corrosive sublimate into the throat, using in cases of children above two years old 1:500 solution, and below that age 1:1000. These pulverizations of the corrosive solution have been repeated every two hours during the day and every three hours during the night. Never in his hands has any accident or mercurial poisoning been constant or fatal.—*Le Scalpel.*

DIPHTHERIA AND MEMBRANOUS PHARYNGITIS.

DIPHTHERIA.

1. It is not common after puberty.
2. The prostration and sense of illness is marked, although the temperature be little elevated and the throat symptoms slight. Briefly, general symptoms more marked than local.
3. Albuminuria is common.
4. The edges of membrane are thin and ill defined, and shade off into surrounding tissue. On peeling membrane a bleeding surface is left.
5. Uvula commonly involved.
6. Membrane does not dip into follicles. (Flint.)
7. No follicular ulceration co-existent. (Scheeb.)
8. The tongue at outset is not usually characteristic.

MEMBRANOUS PHARYNGITIS.

1. It is most common after puberty: not often met within young children. Mackenzie says tonsillitis is more common between fifteen and twenty-five than any other age.
2. The prostration and sense of illness is usually not marked, although the temperature be very high and the throat symptoms severe. Briefly, the local symptoms are more marked than the general.
3. Albuminuria is very exceptional.
4. The edges of membrane are steep and well defined, terminating abruptly. On peeling membrane no bleeding or excoriation.
5. Uvula rarely, but may be involved.
6. Membrane may be seen dipping into follicles. (Flint.)
7. Follicular ulceration present frequently. (Scheeb.)
8. The tongue at outset is frequently characteristically coated with thick yellow-white fur.

—*Australasian Med. Gazette.*

THE INFLUENCE OF THE MIND ON THE BODY.

In an article entitled "Psycho-Therapeutics," which Wm. Dale, M. D., of London, contributes to the *London Lancet*, he presents many interesting suggestions.

Fear, anger, revenge, grief, love, hope, joy, friendship, may all effect physical condition.

As illustrative of the belief in this theory, so early a writer as Churchill says:

The safest way to health, say what you will,
Is, never to suppose we shall be ill;
Most of the ill that we poor mortals know,
From doctors and imagination flow.

The efficacy of strong emotion in producing, or in helping to produce, such conditions as diabetes, chorea, and epilepsy, is well recognized, and, we venture to say, undoubted; but it is always difficult to estimate correctly the influence of such accidents, or to say how much may be due to them and how much to an underlying instability which such a disturbance merely makes evident. That a depressed physical and mental condition also renders the bodily organs more susceptible to the influence of some poison, such as that of the specific fevers, is well recognized; and when the inseparable connection between mind and body, and the profound alterations which fear or joy bring about in (for example) secretory organs, are taken into account, it is not surprising that violent emotion should, as it were, open the gate to allow the admission of sundry toxic influences.

It is an interesting question how much of the general—but by no means invariable—immunity which medical men enjoy from infectious disease is due to the calmness and unconcern with which they regard such disease in relation to themselves. They forget to be afraid, and so they are clothed with an invisible and often an invulnerable cloak.

It appears, then, that Faith and Hope are the two great principles which the physician must encourage to seek to evoke in his patient. The disease to which man is liable may be looked upon as so many enemies which lay siege to the citadel of his life, and often he is so fiercely assailed by them that he finds no help or defense in himself; and it is then that the physician, coming to his rescue with the powerful allies Faith and Hope, may perchance create within him a courage which will enable him to make, at least, a brave stand against his foes.

DIET IN DIABETES.

The following rigorous diet is recommended by Dujardin Beaumetz of Paris: Eggs, fish, meats of all kinds, poultry, game, oysters, fish and cheese.

All green vegetables are permitted except beets, carrots and beans.

Fatty foods are recommended, such as sardines in oil, herring, lard, goose-grease, ham-fat and caviar.

All soups are permitted, when made of meats in combination with cabbage, poached eggs and onions. Put no bread or toast in the soup.

Only dietic breads are to be used and saccharine in place of sugar.

All starch foods are strictly forbidden, as sweet fruits, pastries and chocolates.

Patients may drink claret wine diluted with Vichy, but no poor wines, liquors or spirits.

Daily exercise morning and evening in open air; fencing and gardening and other light exercise.—*Medical Mirror*.

VALVULAR LESIONS OF THE HEART AND PULMONARY TUBERCULOSIS.

Lannois (*Revue de Médecine*, 1892, No. 10, p. 830), calls attention to the infrequency of the association of valvular disease of the heart and pulmonary tuberculosis in the same person, and reports an illustrative case. A blacksmith, thirty-nine years old, had had an attack of enteric fever at the age of five, followed by convulsions; at seventeen, an attack of acute articular rheumatism, with pericarditis; at twenty-three, a second attack of rheumatism, with endo-pericarditis; three years later, a third attack; and three years later, a fourth attack. From the age of eighteen years he had had a winter cough. Following the last attack of rheumatism the appetite had failed, strength and flesh had been lost, and albumin had appeared in the urine. The respiratory murmur became enfeebled below the clavicles; sonorous râles were heard posteriorly and at the bases, while the cough developed sibilant râles. The patient became ill at ease, felt slightly feverish, and took to bed. It was found that the temperature was 105°. Oppression of the chest set in. The sputum became nummular. Sibilant and subcrepitant râles were to be heard. The number of respirations was increased. Dyspnoea became marked and aphonia appeared. The patient grew progressively worse and finally succumbed. At the

post-mortem examination the right pleural cavity was found obliterated by adhesions. Both lungs were congested. Beneath the pleura numerous gray granulations were visible, while the anterior margins of the lungs were emphysematous. On section, granulations, some of which were caseous, were found throughout both lungs, but in greatest number at the apices. The glands at the hilus of the lung were enlarged, but not caseous. The kidneys contained numerous miliary tubercles. The spleen was enlarged, the liver fatty. The heart was bound to the pericardium by old adhesions. Neither the organ nor its serous sac presented evidence of tuberculosis. Both the aortic and the mitral leaflets were thickened and the two valves were manifestly incompetent.—*Amer. Jour. Med. Sci.*

PRIMARY CARCINOMA OF THE COMMON BILE DUCT.

May (*Munch. med. Woch.*, August 16th, 1892) reports the following case in a man aged 67: who was said to have suffered formerly from renal colic. In the winter of 1890 he had influenza, and since then cough and dyspnoea. There were no hepatic symptoms, and he had never had jaundice. About six months later he had symptoms which were apparently due to myocarditis and cardiac dilatation. The liver was then noted as enlarged. In January, 1891, he lost his appetite and began to waste considerably. Jaundice, which had been present for a short time, became intense. It was often thought that this was the result of something more than mere back pressure, but the supposition could not be proved. Later there was general dropsy. In February, 1892, he was suddenly seized with intense pain in the right hydochondrium and vomiting. He died of collapse in two days. The heart was found to be enlarged and dilated, and the substance degenerate. There was suppurative peritonitis. There were a few small stones in the gall bladder, the walls of which were perforated in the one place. Similar stones were found in greater numbers in the cystic duct, and also in the much-dilated common bile duct. At the opening of the latter into the intestine there was an annular mass of new growth, which partly projected into the lumen of the gut. The liver was enlarged, of a dark green color, and

contained secondary deposits of columnar carcinoma. Schüppel says that the characteristic symptoms of this disease are steadily increasing jaundice, showing no improvement, along with symptoms of biliary stasis and hepatic enlargement, but that often the diagnosis is almost impossible. The disease here lasted apparently about a year. Most of the recorded cases have died of pneumonia. It would appear from this case that gall stones play a part in producing carcinoma. Of nine reported cases, however, gall stones were only present in one, and then they were still in the gall bladder. The author calls attention to the well-marked but passing benefit to the appetite produced by orexin in this case.

ITCHING IN SCARLET FEVERS.

This is not always agreeable, but it has never been supposed to be a favorable sign, yet St. Phillippe (Rev. Mens. de Mal de Lienf., February, 1890) presents the following conclusions:

(1) Scarlatina is a disease which is often accompanied by itching. (2) This variety usually has a favorable prognosis. (3) The itching is due to the fact that the eruption is not intense and the cutaneous lesions not very profound.

A good application for the relief of this itching is the following:

R Campho-phenique..... 3 ss
Albolene unguent..... 3 ss.

M. Sig.: Apply night and morning.

Another advantage is that it is in the direction of personal disinfection—*Archives of Pædiatrics*.

SURGERY.

THE RADICAL CURE OF INGUINAL HERNIA IN YOUNG INFANTS.

Until quite recently the general teaching of systematic writers on the subject has been adverse to operating for the radical cure of hernia in very young children. Berger, for instance, basing his opinion upon the frequency of cure by the bandage, deprecated operation upon such subjects. More recent writers, however, have brought forward evidence to justify this operation without reference to the age of the child. Félizet, in his thesis (1891), has reported a successful double operation

upon a child of eight months, the interference being necessitated by the enormous size of the hernial tumors. Broca (*Revue mens. des Maladies de l'Enfance*, April, 1892) does not hesitate to operate after the age of three years, and his seven observations show that the operation itself is not a grave one, and its results can be compared to those obtained in adults. Below the age of two years he does not think operation is justifiable, because the phenomena of strangulation are never grave, and, moreover, antisepsis is difficult to maintain. Karewski (*Berliner klinische Wochenschrift*, March 18, 1891), however, thinks that scrotal hernias can be radically treated without danger, even in infants of the tenderest age. Of the nine children upon whom he thus operated, the youngest was nine months and the oldest two years and three months. In none of these cases did relapse occur, and all recovered without accident. The most recent report of cases comes from Phocas, of Lille (*Le Mercredi, Médical*, 1892, No. 29, p. 341), who gives the notes of two operations, one upon a child of fifteen months, the other upon an infant of four months, both of which gave eminently successful results. This author puts himself in line with the operators already quoted; but he is disposed to believe the conditions changed when the radical operation is practised as the termination of a keloctomy for strangulated hernia, for in this case the tissues are infected and the child in a depressed state; and he considers these facts as warrant for refraining from operation in case of strangulation in children under two years of age. Such a decision, moreover, seems justified by the fact, noted by all observers, that strangulation at this age is a relatively benign accident. In many cases simple taxis is sufficient, and sometimes the condition yields spontaneously. Nevertheless the diagnosis of strangulation is surrounded by so many difficulties in these very young subjects, that statistics have little weight. On the other hand, the existence of a hernia, which cannot be satisfactorily controlled by any of the palliative means, is a source of so much annoyance and suffering to the infant that measures for radical relief are, in many cases, peremptorily demanded. The operation promises better success, of course, when practised in the absence of strangulation, and the author

would not hesitate to reduce a strangulated hernia by taxis, waiting for a more favorable time to attempt the radical cure. As a general rule he believes it to be sufficient to extirpate the peritoneo-vaginal canal, whose abnormal persistence is the sole cause of this hernial defect.—*Amer. Jour. Med. Sci.*

TREPHINING FOR RELIEF OF INTRACRANIAL PRESSURE.

That in cases in which an intracranial growth is present much relief is at times given by trephining is now well known, but the number of cases as yet reported is too small to allow of its being recognized as a certain, and at the same time, a safe means of treatment. Such treatment, of course, is only applicable to cases in which either the new growth is too large for removal, or its locality cannot be definitely diagnosed. As regards growth in the cerebellum, clinical observation is still at fault. While in some cases it may enable us to say with a fair amount of definiteness that there is a cerebellar tumor, in very few can it be predicated on which side of the cerebellum the growth lies. Every recorded case, therefore, is of extreme importance, as enabling a judgment to be formed of the difficulties and drawbacks which follow such an operation, as well as of the relief experienced and the nature of the cases in which the operation may be expected to have a favorable result. In the *Journal of Nervous and Mental Diseases*, Dr. Knapp, of Boston, reports a case in which diagnosis was very difficult, and in which an operation was undertaken chiefly for the purpose of relieving symptoms resulting from increased intracranial pressure. The patient had been fairly well till October, 1889. He then began to suffer from occasional severe headaches, and at times dimness of sight. He was seen at this time to have double optic neuritis. He lost the sense of smell early in the illness, and became totally blind in August, 1890; but on one occasion, after a severe attack of vomiting, he is said to have had a temporary return of vision. He was seen by Dr. Knapp in October, 1890, and then he had for three weeks complained of failure of hearing in the left ear, had experienced some difficulty in swallowing, and there was a profuse flow of saliva. He had also had on two occasions attacks in which he cried

out, fell down, and frothed at the mouth. He likewise had sensations of numbness of the face and hands, but tactile sensibility was fairly good. He suffered from headaches, and was restless and slept badly. There was pain on pressure on a spot in the right temple. Sometimes neither knee-jerk could be obtained; at other times only the right was present. Trephining was advised, and was performed on Jan. 18th, 1891. Bone was removed in the right parietal region, just behind the anterior end of the fissure of Sylvius. There was bulging at the opening; but no tumor was felt or seen even after the opening had been considerably enlarged. After the operation he was more comfortable, although not quite free from headache, and at his own request he returned home on Jan 28th. He returned a few days later, apparently suffering from left hemiplegia and hemianæsthesia, and he remained in a very somnolent condition of some days. There was oozing of blood from the posterior end of the incision which had apparently broken down, and later on some brain substance came away. On Feb. 14th he became almost comatose but a profuse watery discharge from the wound set in, and he began to improve. There was no change in the condition of the hemiplegia, or any sign of returning vision, but his mind was much clearer. The hernia, however continued to slough, and on March 7th he suddenly became worse, and died on the 9th. At the necropsy there was found signs of meningitis around the trephine opening, and a large tubercular tumor in the left lateral lobe of the cerebellum. Of course, in such a case operation was a forlorn hope, for there was little probability that even vision could have been to any extent restored, and it was also a misfortune that breaking down of the scar should have occurred with the consequent hernia cerebri; but the temporary relief from pain, although brief, is significant.—*Lancet*.

FIXATION OF CATHETERS.

Pilz, of Vienna, describes an ingenious and apparently efficient way of fastening catheters used for continued drainage of the bladder when passed per urethram. It consists of inserting the catheter in the usual manner so that the "eye" is just inside the internal sphinc-

ter; the catheter is then transfixed with a pin at its point of emergence from the meatus, which prevents its entering farther into the bladder. It is kept from slipping out of the urethra by a strip of adhesive plaster passed over the pin and the ends fastened to the dorsal and ventral surface of the penis. These latter are prevented from slipping by other strips circularly applied, which also, it is claimed, prevent erection. Lauenstein, in cases of perineal section, fixes the catheter by a ligature passed through it through the perineal wound. The ends of this ligature are then tied over the iodoform gauze tampon which lies in the perineal wound, and thus fixes the catheter.—*West. Med. Rep.*

USE OF NITRATE OF SILVER IN URETHRAL INFLAMMATIONS.

Dr. R. Guitéras (*Journal of Cutaneous and Venereal Diseases*) says:

Nitrate of silver is not dangerous in acute urethral inflammations as is generally supposed.

By beginning with small doses and increasing daily a tolerance can be established (the same as in chronic cases).

Although a solution of the strength of 15 or 20 grains to the ounce can be reached in this way, it is not wise to go above 8 or 10 grains; and then if the result is not favorable to continue with some other means.

In this, as in bichloride irrigations, and all other methods which try to cure this trouble quickly, a dry, congested and slightly irritated condition is liable to follow, which should be treated for some days by mild astringents, these to be left off gradually.

When the discharge becomes very slight, it is better at times to decrease the strength of the arg. nit. than to increase it.

In cases of gonorrhœal cystitis, which are usually acute, good results are obtained by instillations of this drug.

In cases of chronic deep urethral inflammations, especially those of a granular nature, deep urethral injections are the remedy *par excellence*.

Nitrate of silver as an abortive should not be used, as in doing this peri-urethral inflammations may be set up, which might cause considerable trouble.

ISOLATED HERNIA AND STRANGULATION OF THE APPENDIX VERMIFORMIS.

THIÉRY (*Bull. de la Soc. Anat. de Paris*, July, 1892) reports a very rare, if not unique, case of isolated hernia of the vermiformis. A man, aged 58, came under the care of M. Verneuil with a very large, tense, and painful swelling in the left groin. This swelling had been noticed for eight months, but could always be readily reduced until three days previously, when in a brisk movement the man was suddenly seized with pain in the affected inguinal region. Subsequently he vomited frequently, but up to the time of admission his bowels had been frequently relieved, and gas could be passed by the anus. On incision of the inguinal swelling, which resembled in every respect a strangulated hernia, it was found to be made up of numerous layers of brownish, infiltrated and friable tissue. At the bottom of this thick mass a small cavity was opened, which contained a small quantity of fluid with a strong faecal odour. On opening up this cavity which proved to be a narrow peritoneal sac, a gangrenous cord was exposed, which, after section of the constricting neck of the sac, was traced upwards and found to be the distal portion of the appendix vermiformis, measuring about 8 inches in length. This had been tightly strangulated at the junction of the inferior with the middle third. It was gangrenous below the constriction and perforated at its extremity. A ligature was put around the appendix close to the cæcum, and nearly the whole of the process was removed. The infiltrated structures forming the bulk of the inguinal tumour were carefully dissected away. The patient made a good recovery. —*British Medical Journal*.

THE RESULTS OF 572 TRACHEOTOMIES FOR DIPHTHERIA.

Habs (*Deutsche Zeitschr. f. Chir.*, Band xxxiii., Heft 6) reports 572 cases of tracheotomy for diphtheria, with 316 deaths, or a mortality of 55¼ per cent., extending over a period of six years, and showing a decrease of nine per cent. between the first and last periods of three years each. The operation was most seldom performed in April, May, June, July, and August, and during these months the per-

centage of mortality was likewise the least. It increased gradually from that time, reaching its maximum in March, then decreasing. The average length of treatment was sixteen to twenty days. The most children died in the first five days after the operation, nearly as many dying on the fourth day as on the day of operation; then the danger decreases till the eighth or ninth day, when pneumonia is to be feared as a cause of death. A relatively good prognosis can therefore be given in those cases in which the patient passes the fifth day, except where intercurrent complications appear. The best cases are those in which, after the operation, the breathing is free, no membranes are found, the pulse good, fever slight, and little albumin is present in the urine; while those cases are unpromising in which the breathing is not free, where slight retraction of the chest walls continues, and deep-seated membranes or a tendency to pneumonia are present—yet they are not hopeless, and, on the other hand, even in the most hopeful cases there are the secondary sequelæ to be feared.

The mortality is very high in the first two years of life, then falls, rising again during the sixth and ninth years to forty per cent., and after the tenth rising again to fifty-nine per cent.; this is to be accounted for by the severe type that attacks older children. There is a greater percentage of deaths among male children than among female, and also more males are attacked by the disease.

[These results, which seem to show a percentage of recoveries of 44½ per cent., are more favorable than are usually obtained in this country, where I believe the figures show 28 to 33 per cent. of successes. It is probable that H.'s cases were operated upon at a very early stage, as hospital patients abroad usually submit more promptly and unquestioningly to surgical measures than in America.—J. W. W.]—*Amer. Jr. Med. Sci.*

PROSTATECTOMY.

The following new method in prostatectomy is described by Tobin (*Medical Press*, September 21, 1892). After supra-pubic cystotomy has been performed, and the diagnosis of enlarged prostate confirmed, a straight urethral écraseur is passed *per urethram* until the point touches the pros-

least. time, on de- treat- The e days dying opera- all the a is to tively en in es the com- those reath- d, the umin cases atching of the seated monia peless, most ry se- e first again forty again is to e that greater ildren males how a cent., ally ob- ve the of suc- es were age, as submit gly to a.—J.

tate at the level at which it is desired to operate; the wire loop is then opened and made to encircle the portion to be removed, an incision being made with scissors if required; the loop is then kept imbedded by two fingers passed through the abdominal wound, and, guided by them and the écraseur, cuts in the plane desired. The lateral lobes may be removed in like manner, incisions being made if required for the passage of the loop. The author claims the following advantages for this method: "1. As much of the gland as interferes with the escape of urine is removed, and no more. 2. Such portion is removed in a satisfactory manner, for the wire cuts up to the portion where the instrument has been stopped by the obstruction. 3. A smooth surface sloping into the urethra is left, instead of the more or less rough one that must result from taking away the gland piecemeal with a forceps. 4. There is very little hemorrhage." He also recommends the Trendelenburg position, and reports a case of recovery with perfect function in the sphincter, and no re-obstruction after six months.

OBSTETRICS.

CONVULSIONS AT SIXTH MONTH: NO PREMATURE LABOR.

Puech *Nouv. Montpellier Méd.*, No. 31, 1892) attended a primipara, aged 23, who was admitted into hospital for severe eclampsia during the sixth month of pregnancy. There seemed no tendency to delivery. She was at once placed under chloroform for three hours, but every time the administration was slackened convulsive movements began. Afterwards a severe convulsion set in, followed by coma. As insensibility became profound, free venesection from the arm was practiced; at once the patient's condition improved, respiration became less embarrassed, and the temperature fell from 103.6° to 101°F. an hour after the bleeding. Chloral was given, and the patient steadily improved. Albumen, which at first abounded in the urine, at length almost disappeared, the patient completely regained her senses, and the foetal heart sounds were found to be still audible. When the report was published, there seemed every chance that the patient would continue her pregnancy to term.

THE MORPHOLOGY OF BREAST MILK AND THE NUTRITION OF THE CHILD.

An extensive study by Ivanhoff (*Thèse de St. Petersburg, 1890*) of this subject led him to the following conclusions.

1. The cellules of colostrum are of epithelial origin.
2. The multiparæ colostrum changes to milk more rapidly than in primiparæ.
3. Puerperal diseases retard the disappearance of the colostrum corpuscles.
4. These corpuscles reappear in the milk after ten months of lactation, and when the infant is only partly fed from the breast.
5. The free hyaline corpuscles, as well as those which are enclosed in the fatty globules, form a constituent of normal milk at a certain period of secretion.
6. Good health, good nutrition, and youth in the mother give a milk richest in fatty globules of large size, as is also true of the cellules.
7. The last portion of milk taken at a feeding holds fewer globules, and these of smaller size than the first portions.
8. The estimation of the nutritive quality of milk should be based upon the number of fatty globules; and, secondarily, upon their size, the quantity of cellular element, and, finally, upon the quantity of granules.
9. Milk which contains a very large number of fatty globules (more than 3½ per cent.) is not well borne by very young infants.
10. Milk, the globules of which are large, is less nutritive and less well borne.
11. The maximum of daily increase of weight of the child is produced by milk which contains a mean quantity of fatty globules of medium size (27.7 grammes daily).
12. The milk which contains few fatty globules gives little increase of weight (16 grammes daily); and the same is true if the fatty globules are in too great quantity or are too large (19 grammes daily).
13. Women who are thin and young in general are the poorest nurses, often making the children dyspeptic and giving them a mean daily increase of weight of only 11.5 grammes.
14. The microscopic examination of a freshly secreted milk gives a sure indication of its nutritive value.

FEVER IN RECENTLY DELIVERED WOMEN.

Crouzat (*Midi Méd.*, July 9th) strongly advocates the popularisation and general diffusion of complete antiseptics from the first in all labors, however simple; otherwise a strong, healthy young woman may often be lost, and for such a loss the obstetrician or midwife is responsible. Crouzat describes a sad case of this kind. The patient, aged 26, was naturally delivered on the night of May 29th; the placenta came away entire, and she did well till the second day, when rigors and fever set in. The abdomen became distended. The blood drawn from the patient's finger was full of streptococci, and set up erysipelas when inoculated into a rabbit's ear. The patient died on June 6th. The uterus was fixed by solid inflammatory deposit which filled the fornices. The public and the profession must understand that "milk fever" does not exist. A rise of temperature of over 100° in a patient delivered within two or three days should at once awaken suspicion of puerperal infection, and rigorous antiseptic treatment will at once be needed. Yet, with the greatest skill and care, the patient may be lost. Hence it is the duty of the obstetrician to prevent any chance of such rises of temperature by taking strict antiseptic precautions in the conduct of all cases of labor.

MISSED ABORTION: OVUM RETAINED—ELEVEN MONTHS.

Budin (*Nouv. Arch. d'Obstét. et. de Gynéc.*, October, 1892), read this case at a meeting of the Obstetrical Society of Paris in July. The patient, aged 24, was a married Russian medical student. The last period, very profuse, was seen at the end of June, 1891, then her first pregnancy began. Morning sickness was severe. Early in November, when starting for France, she was upset out of her carriage into a river. She felt no shock, and continued her journey. At Berlin, pains set in, with "show." When she reached Paris the symptoms of miscarriage increased. After fifteen days' rest she got up. Slight hæmorrhage became almost constant. On March 28th, 1892, Budin examined her, and diagnosed retention of the dead ovum. The patient was watched; on June 14th a gum catheter was passed into the uterus. Contractions were set

up next day by the introduction of a pig's bladder into the vagina, gradually distended with water, and held in place against the upper limits of the vagina by an air pessary. Pains set in, followed by great excitement, and then lethargy. The bladder was therefore removed four and a half hours after its introduction. Injections of sublimate were thrown up, uterine contractions became severe, then the alarming symptoms recurred. Some old decomposed clots came away, and early next morning a great fleshy mass was expelled. A rigor followed, but thenceforward the patient did well. The fleshy mass was the ovum long blighted by hæmorrhage. The fœtus had been completely destroyed. Amniotic and placental tissues were detected by microscopic examination.

GYNECOLOGY.

PRIMARY CANCER OF LABIUM.

Zeiss, of Erfurt (*Centralbl. f. Gynäk.*, No. 40, 1892) was consulted in 1887 by a robust woman, aged 38, the mother of three children. She had noticed a small tumor in the external parts for four or five months. For four weeks it had caused pain. It formed a swelling of the size of a hazel nut in the posterior part of the right labium minus; its inner aspect was ulcerated. The inguinal glands were not involved. Zeiss carefully amputated the entire labium with Paquelin's cautery. The microscope proved that the growth was cancerous. In 1889 she became pregnant, 1890, she bore a child, and when suckling it, a swelling developed in the left breast. It slowly grew, and in the summer of this year began to be the seat of lancinating pains, most marked in bad weather or during menstruation. In February, 1892, irregular flooding began. In August, exactly five years after the removal of the labial cancer, Zeiss examined her once more. She was very much emaciated. The cervix was partly destroyed by a large excavated cancer, the uterus could not be removed. The inguinal glands were not involved, the scar of the old operation wound on the site of the labium was healthy. The left breast was the seat of scirrhus with retracted nipple, and two axillary glands were enlarged. There was no evidence of metastatic deposit in the viscera.

A CASE OF VAGINISMUS.

About five months ago Mrs. N. M.—called upon me, from New Jersey, with the following history: She had been married five months, had always enjoyed perfect health, although she was of a somewhat nervous disposition and anæmic. Quite soon after her marriage coition had become impossible. The accompanying pains were something intolerable at first, making, as stated, coition entirely impossible. There was no discharge, no leucorrhœa: defecation and urination were without pain and regular; appetite good.

Upon my request that a thorough examination of the parts locally would be necessary, she gladly consented, but doubted the possibility of a digital examination. As she lay upon my operating table, inspection showed nothing but a slight œdema and redness of the external parts. Upon my attempt to introduce my index finger, the muscles of the floor of the pelvis became suddenly perfectly rigid, the muscles of the thighs began to contract spasmodically, the patient cried and complained that I was causing her the most agonizing pain. No amount of persuasion could induce her to become quiet or calm, and as she became more and more hysterical I was compelled to desist from all further examination.

I had not even been able to separate the labia, nor had I been able to see the hymen, or what was behind it.

A second examination, a week after, was even less successful than the first. The pains had grown more intense, the parts so hyperæsthetic that even the clothes coming in contact produced great agony. Her condition was deplorable, and her marriage life was far from being a happy one.

There was no doubt that the existing symptoms were those of vaginismus, the cause of which I had not as yet been able to detect. Consequently it was considered best to anæsthetize her and act at once according to the existing lesions.

When perfectly under its influence, and the parts had thoroughly relaxed, my finger entered the introitus vaginæ without the least resistance. The uterus and vagina were explored, but nothing abnormal could be detected.

Nevertheless, a close ocular inspection revealed the following conditions: The

hymen had been lacerated into four distinct parts, each of which was more or less triangular in form. On the apices of each of these a small hypertrophic nodular mass (like corns on the feet), of the most extreme sensitiveness, was detected. Naturally I resorted at once to the excision of the entire hymen. There was but little hæmorrhage; the resulting raw surface was left to cicatrize. A tampon of unguentum iodoformi was inserted into the vagina, large enough to distend the entire cavity thoroughly. Calling upon my patient the next day, I could realize at once the success of my operation as experienced by her countenance.

She could change the tampons and irrigate the parts with but little annoyance, except, as she states, a feeling of slight soreness. The introduction of tampons was continued for about ten days longer. The small wounds healed admirably. There was no more pain. She is now pregnant.

RUPTURED TUBAL PREGNANCY.

Mersch (*Centralbl. f. Gynäk.*, No. 44, 1892) not long ago exhibited a most instructive specimen before the Obstetrical Society of St. Petersburg. It was a tubal pregnancy discovered at a necropsy on a woman who had died of phthisis. The tubal sac had burst. The skeleton of the fœtus was found strongly adherent to the lower end of the mesentery. The soft parts had been almost completely absorbed. The entire process must have caused but little general disturbance, for there was no history of any serious illness excepting pulmonary disease.

NEWS AND MISCELLANY.**THE DISEASE OF INEBRIETY.**

Statistics of persons arrested for inebriety, extending over long periods, will point to certain years in which a maximum in numbers was reached, followed by a retrograde movement back to minimum. This tide-like movement is sometimes clear, then obscure. Often it is marked by both epidemic and endemic waves, and is traced in the prevalence of inebriety in towns and cities, and in the reaction noted by temperance revivals. This psychologi-

cal ebb and flow was pointed out by Dr. Westphal in Sweden many years ago, and an interval of seventeen years was indicated as the time between the maximum and minimum periods of inebriety in that country. Shorter periods have been noted by other observers in different countries. Many very startling facts point to this wonderful cycle and drink orbit, and help to explain the strange temperance revivals which spring up and sweep over the country, dying away with the same mystery and suddenness. Such movements are undoubtedly the backward swing of high tides of inebriety. The histories of large cities and towns supply many startling confirmatory facts of periods of inebriety and intense temperance revivals following each other with a strange, fascinating mystery. Like the ebb and flow in politics, religion and the great social movements, these drink cycles or waves point to ranges of causes and conditions awaiting future discovery. While many of the causes of inebriety as seen in the individual are both preventable and curable, there are other unknown psychological and physical forces that control the form and direction of the inebriety of both sexes. Whatever inebriety is in Europe, or may have been in the past, it is in this country a brain and nerve disease, marked by mental and physical failure, exhaustion and central degeneration.—*T. D. Crothers, M. D., in North American Review.*

EVIL LITERATURE.

Bad readings do an immense amount of harm to the young, who are given to imitate these heroes of fiction or of theatre, above all whenever the publication or drama presents vice under attractive colors. Children cannot without danger read, nor see, nor hear everything; ignorance of evil is the best safeguard of a child's morality. The automation which is in each one of us, according to the deep observation of Pascal, is particularly inclined in childhood to reproduce acts the portrayal of which provokes emotion. That is why Plato did not believe that all sorts of fables indifferently could be told to children, and considered as detrimental to morality the tales of criminal deeds which the poets ascribed to the gods. The souls of youth, as their bodies, require a pure

atmosphere, amid which they may develop in kindness, purity and courage.

The physicians and criminalists who understand the power of good and bad example would—with propriety—prohibit the press from parading in the newspapers the unhealthy outbreaks of society's moral infirmities, of its suicides and crimes; they fear, with cause, the effect of this publicity on the weak and sickly minds (for all the insane are not in the asylums), on the young men and nervous women. The details furnished upon the execution of suicides and crimes generally strike the mind and may awaken a spirit of imitation. This publicity, moreover, presents the very grave inconvenience of teaching the details of execution of criminal acts.—*Translation from Louis Proal, in The Summary.*

THE TREATMENT OF DELIRIUM TREMENS.

The author asked first, What was delirium tremens? Was it a morbid state, which was the issue of neurasthenia, or was it an effect of alcoholic poisoning? He believed it to be the latter, and that the disease arose from the cumulative specific action of the poison of the cerebral tissues through the alcoholization of the blood. Acting on this theory, he had aimed at eliminating the poison from the brain and nervous system, leaving the healing power of nature to do the rest. This was the view taken in 1854 by Dr. Alexander Peddie, who administered antimony. Dr. Kerr, however, has found liquor ammonii acetatis to satisfactorily fulfil the conditions most favorable to cure. The main point was to avoid the use of alcohol and opiates, chloral, and all narcotics. The best hope of cure lay in natural exhaustion inducing sound, refreshing sleep.

The differing results of narcotic and non-narcotic treatment were exemplified in the case of a publican, who, in his second attack, was treated with opium and bromides, and in his third attack only with liquor ammonii acetatis. In the former seizure the patient, aged 48, even after sleep, was so heavy, unrefreshed, and then violent, that it took four men to hold him. To save his life he had to be put

into a padded room in the work-house, where he raved till exhausted and procured sleep, his only beverage there being coffee. In the latter seizure, two years afterwards, he was treated at home, the only medicine being liquor ammonii acetatis, at first in drachm doses every hour; milk, beef-juice, broth, and coffee were given frequently. In about seventy hours he had a sound sleep for four hours, followed in four hours more by a spell of twenty hours' sleep. The latter attack was complicated with an epileptic fit. The recovery was quicker than from the previous attack. These were both typical examples of the graver form of delirium tremens. By a reliance on so safe a sudorific as liquor ammonii acetatis and suitable nourishment, we best fulfill the conditions of cure, as we hereby give the *vis medicatrix nature* a fair field and no favor. —*Thera. Gazette.*

BURNS OF THE EYES.

Dudley S. Reynolds (*Jour. Am. Med. Association*), after referring to the various substances, as quick-lime, ammonium, nitrate of silver, sulphate of copper, caustic potash, and fused metals, which may produce burns, and to the use of the chemical substances which may be utilized for neutralizing them; for instance, the free ablutions of vinegar, and followed by a weak lotion of chloride of sodium in the cause of caustic potash, condemns the practice of closing the eyes that are so affected. In his belief the use of oils, and especially castor oil, so much in favor with the profession, produces in all cases an increase of irritation. Whenever any mucous membrane is wounded, and it becomes necessary to make local applications to it, the chemical combinations of the fluid covering that membrane in its normal condition should be considered in devising the plan of treatment. Inasmuch as the conjunctiva in its normal state is constantly bathed in a fluid rich in chloride of sodium, this salt should enter into nearly all local applications designed to remove offending matters. In one case of a severe lye burn of the eye, which had first been treated with the instillation of vinegar, Reynolds used with satisfaction the following lotion:

R Borate of sodium..... 5 lias.
Chloride of sodium..... 5 ss.
Distilled water..... 8 xii.
Camphor-water..... 8 iv.

The reporter considers that burns so extensive as to make it impossible to prevent adhesions between the lid and the ball may be greatly modified by leaving the eye open, and daily separating the opposed abraded structures with a probe annointed with a yellow oxide of mercury ointment. —*Ther. Gazette.*

The Trustees of the Methodist Episcopal Hospital, at the December meeting, elected Dr. Geo. E. deSchweintz and Dr. Alexander Randall, ophthalmologist and aurist, respectively, of the consulting staff of the Hospital.

DIPHTHERIA.

The following new combination is recommended by Ozegowski in the *Nour-ing Lekarskie*:

R Iodine.....
Carbolic acid..... } aa 3 to 5 grams.
Citric acid.....
Brandy enough to make..... 100 "

M. Sig: Apply on cotton compress to the diphtheritic membrane.

OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT, U. S. ARMY FROM DECEMBER 11, 1892, TO DECEMBER 17, 1892.

Leave of absence for four months, with permission to go beyond sea, is granted Captain Peter R. Egan, Assistant Surgeon, U. S. Army.

The leave of absence granted Captain James D. Clennan, Assistant Surgeon, U. S. Army, is extended thirteen days.

Lieutenant Colonel William D. Wolverton, Deputy Surgeon-General, U. S. Army, is relieved from duty at Fort Schuyler, New York, and will report in person to the Commanding Officer, Watervliet Arsenal, West Troy, New York, for duty at that Arsenal.

Upon the recommendation of the Medical Director, Department of California, First Lieutenant Charles Wilcox, Assistant Surgeon, will report to the Commanding Officer, Presidio of San Francisco, for temporary duty at that post, until the departure from Angel Island, Cal. of Major William H. Gardner, Surgeon, when he will proceed to Angel Island, and report to the Commanding Officer of that post for temporary duty.

Leave of absence for two weeks on surgeon's certificate of disability, with permission to apply for an extension of two weeks, is hereby granted to Captain Adrian S. Polhemus, Assistant Surgeon, U. S. Army.

**OFFICIAL LIST OF CHANGES OF STA-
TIONS AND DUTIES OF MEDICAL
OFFICERS OF THE U. S. MA-
RINE HOSPITAL SERVICE
FOR THE EIGHT
WEEKS ENDED
DECEMBER
10, 1892.**

Purviance, George, Surgeon, detailed as chairman of Board to consider changes in uniform, Dec. 6, 1892.

Hutton, W. H. H., Surgeon, relieved from duty at Cape Charles Quarantine, to rejoin station, Nov. 29, 1892.

Hamilton, John B., Surgeon, granted leave of absence for six days, Nov. 18, 1892.

Sawtelle, H. W., Surgeon, granted leave of absence for seven days, Nov. 9, 1892.

Austin, H. W., Surgeon, detailed as member of Board to consider changes in uniform, Dec. 6, 1892.

Stoner, G. W., Surgeon, granted leave of absence for fourteen days, Dec. 9, 1892.

Godfrey, John, Surgeon, to proceed to the city of Mexico on special duty, Nov. 22, 1892.

Irwin, Fairfax, Surgeon, to proceed to Europe on special duty, Nov. 22, 1892.

Mead, F. W., Surgeon, detailed as recorder of Board to consider changes in uniform, Dec. 6, 1892.

Carter, H. R., Surgeon, relieved from duty at Cape Charles Quarantine to rejoin station, Oct. 20, 1892. Relieved from duty at Cincinnati, Ohio; assigned to duty at Norfolk, Va., Oct. 26, 1892.

Banks, C. E., passed Ass't. Surgeon, granted leave of absence for fifteen days, Oct. 24, 1892.

Glennan, A. H., passed Ass't. Surgeon, granted leave of absence for thirty days, Oct. 26, 1892.

Bratton, W. D., passed Ass't. Surgeon, granted leave of absence for thirty days, Nov. 10, 1892.

Cobb, J. O., passed Ass't. Surgeon, granted leave of absence for sixteen days, Dec. 7, 1892.

Guiteras, G. M., passed Ass't. Surgeon, relieved from duty at Gulf Quarantine. Assigned to temporary duty at Baltimore, Md., Dec. 1, 1892.

Goddings, H. D., passed Ass't. Surgeon, to report in Washington, D. C., for special temporary duty, Nov. 30, 1892.

Hussey, S. H., Ass't. Surgeon, to proceed to South Atlantic Quarantine, for temporary duty, Oct. 26, 1892.

Perry, J. C., Ass't. Surgeon, when relieved at Norfolk, Va., to rejoin station at Mobile, Ala., Oct. 26, 1892.

Young, G. B., Ass't. Surgeon, granted leave of absence for twenty-one days, Oct. 27, 1892.

Stimpson, W. G., Ass't. Surgeon, to proceed to Baltimore, Md., for temporary duty, Dec. 5, 1892.

Gardner, C. H., Ass't. Surgeon, ordered to Portland, Or., for temporary duty, Oct. 25, 1892.

Nydegger, J. A., Ass't. Surgeon, to proceed to Gulf Quarantine for temporary duty, Dec. 1, 1892.

Strayer, Edgar, Ass't. Surgeon detailed as inspector of immigrants port at Boston, Mass., Nov. 22, 1892.

B & O'S NEW THROUGH LINE.

**PREPARING FOR THE IMMENSE TRAFFIC
INCIDENT TO THE WORLD'S FAIR.**

The management of the Baltimore and Ohio Railroad is preparing for an immense business in 1893 while the World's

Fair is open in Chicago. The terminals at Chicago are capable of accommodating a much heavier traffic than is now being done, and important changes are being arranged for the handling of very heavy freight and passenger business to the West from New York, Philadelphia and Baltimore. New equipment for largely increased passenger business and an extensive stock of freight cars have been ordered. The various roads of the system will be improved by straightened lines, reduced grades, extra side tracks, and interlocking switches. The new line between Chicago Junction and Akron has shortened the distance between Chicago and tide water twenty-five miles, and between Pittsburg and Chicago fifty-eight miles.

The distance between Chicago and Pittsburg and Chicago and Cleveland by the construction of the Akron line and the acquisition of the Pittsburg and Western line and the Valley Railroad of Ohio, is about the same as via the Lake Shore from Cleveland to Chicago, and by the Pennsylvania from Pittsburg to Chicago. The alignment is to be changed and grades reduced to a maximum of twenty-six feet. It is expected that in twelve months the old Baltimore & Ohio through line between Chicago and the Atlantic Ocean will have passed away and the new line via Pittsburg be established, with no greater grades or curvature than on any of the trunk lines.

Work has already begun east of Pittsburg to meet improvements making west of Pittsburg. These improvements will consist of additional second and third tracks, a general correction of the alignment, and completion of the double track on the Metropolitan Branch. It is expected that the new through line will be ready simultaneously with the completion of the Belt Line through the City of Baltimore, which is intended to unite the Washington Branch with the Philadelphia Division and do away with the present line via Locust Point. Forty new and powerful locomotive engines were added to the equipment during the last two months, and others are in process of construction. The permanent improvements now under way and in contemplation involve the expenditure of some five million dollars. —*Baltimore American.*